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ORIGINAL LECTURES.

CLINICAL LECTURE ON ACUTE CATARRHAL PNEUMONIA.

Delivered at Philadelphia Hospital,

BY JOHN M. KEATING, M.D.,

VISITING OBSTETRICIAN TO THE HOSPITAL, AND LECTURER ON DISEASES OF WOMEN AND CHILDREN.

GENTLEMEN: The child which I bring before you is about fifteen months old. About ten days ago my attention was then called to it, suffering as it was from a serious cough of a croupy character, which seemed wholly laryngeal; difficulty in swallowing and some tenderness about the angle of the jaw, and very slight swelling of the tissues on the outside. An examination of the throat showed that the tonsils were enlarged and inflamed, the mucous membrane seemed throughout much congested and angry-looking, but there was at that time no membrane. There was but little fever, and the derangement was seemingly of little importance, and treatment held it for a time in abeyance. Yesterday the conditions just described again appeared with greater intensity, and I bring the case before you this morning that we may study it together.

You will notice that though the infant has an expression of sickness—that it is pale, languid, and in evident suffering—it has not the stupor which would be characteristic of some blood-poisoning. Its eyes are bright, it notices the class, and taking the subject as it lies in its mother's arms, you would say that child is sick, probably very ill, but its disease is not one in which the nerve-centres are either irritated or overcome by poisoned blood. You will notice that it has not the appearance of a high febrile state—in fact, its temperature is slightly elevated. I carefully examine the contour of the submaxillary region, and I find no evidences of swelling, nor do I find enlargement of the glands upon pressure, nor, in fact, tenderness. I notice that the return blood-current of the neck does not seem interfered with. I find the pulse quick, but firm and regular, and of moderate force, the respirations are quicker than normal. There have been no cerebral symptoms.

I examine the throat, and find the mucous membrane much congested. A glimpse, which I get after a little manipulation with this spoon-handle, leaves no doubt in my mind that there is entire absence of membrane. The anterior arches and the tonsils, though covered with glairy mucous, which is tenacious, have not that coated appearance which is so characteristic of diphtheria—the appearance of having been whitewashed—which, if you have once ever seen, you will never forget. The membrane of diphtheria is white or gray, firmly adherent to the mucous membrane, for, in fact, it forms on the mucous membrane from the subcutaneous tissue, and clings so tightly to the surface as to require force to detach it, denuding the mucous membrane of its epithelial layer. Do not imagine that every patch you see in a child's throat means diphtheria. Milk curds, or even mucus, may deceive you. As the coating of the tongue is accepted as an index to faulty intestinal secretion and gastric disturbance, an inflammation of the mucous membrane of the throat, as severe as you see it in this child, leaves with you the impression that its severity is not limited alone to that part, but must extend into the respiratory tract.

I may tell you that after careful inquiry I find that this child has no intestinal disturbances of any account; we will, therefore, give attention to its lungs, for evidently we have here the seat of a lesion severe enough to give rise to these outward signs of illness which are so prominent. I place the child upon the mother's shoulder, letting its head rest to one side, and in that way giving a straight back for an examination. Upon percussion I find upon the left side normal resonance—that is to say, normal for a child; such sounds in an adult would be considered hyper-resonant, and denote emphysema; probably in this case it is even of higher pitch than it should be for a child; if so, it will be due to obstructive disease of the other lung, and the exaggeration will be caused by the overwork at aeration; but this being elicited only by comparison with the other side, cannot be noted at present. Upon auscultation, I note the usual puerile breathing, and in addition a quantity of large, coarse, mucus râles, both upon inspiration and expiration, which become more numerous as I approach the centre of the back. Let us now examine the right chest. Here I find upon percussion of the posterior surface a lower pitch, a marked contrast to the other side. There is less of that puerile resonance which I told you was found in infants at this age; and, although you can readily notice that there is no absolute dulness, the impairment, down to the angle of the scapula, is well marked. I may tell you that I notice a want of resiliency upon this side, and I can thus establish another difference. You may note, again, that when this right side is examined and firmly pressed upon it gives the child great annoyance; this is not the case if I press, however firmly, upon the left chest.

As I listen to the point at which I noted the impairment of resonance, which, in fact, comprises the scapular region, I do not find as many mucous râles; I occasionally note them in the larger tubes, but in their place there is a harsher, more grating, to-and-fro respiratory sound, with occasionally fine crackling râles, heard in both inspiration and expiration. The air vesicles still receive and discharge air, but seemingly with greater difficulty, as the inspiratory murmur is long and rough, and the expiratory one is prolonged and equally harsh. The sounds seem close to the ear, but I cannot detect any rough rubbing murmur or vibrations that would note pleurisy, nor again any evidence of a plastic pleural deposit that would account for the impairment in percussion resonance. We certainly, then, have an inflammatory trouble to deal with, which does not present either in its rational or physical signs the symptoms of acute croupous pneumonia, nor of pleurisy, but coincides in all its features with a localized catarrhal pneumonia; in other words, with a perivesicular inflammation, resulting from an extension of the bronchitis. This means an inflammation of the connective tissue which surrounds the minute bronchi and the air vesicles, and being congested and inflamed, increases by the vivification of its nuclei, grows rapidly in size, gives us the percussion dulness, presses against the air vesicles, and so crowding them, either causes them to collapse or their inner walls to become adherent, and so diminishes their calibre as to cut off that much of the aerating surface, and throws extra work upon the other lung or the healthy portion of the one diseased. Fortunately for our study, this child has remained quiet during the examination; but should it become fretful, and finally

excite its circulation by a crying spell, and thereby require more and quicker oxygenation of blood, you would see the immediate exaggeration in all the physical signs, and the diagnosis would be rendered more easy by the positiveness of the symptoms.

Complete consolidation may take place, and the lung become carnified; there would then be absolute flatness in percussion. Such a case we have at present in the ward, in a child of two years, and which I hope, at my next clinic, to exhibit to you; but, in that case, we have the whole upper lobe principally affected. In this disease there is not usually a solid mass of consolidated lung found closely following the initial symptoms. Though the area of disease may be circumscribed, as it is in this case, scattered throughout the diseased part are to be found healthy lobules, lying side by side with those affected with the catarrhal inflammation, and then, consolidation or condensation of tissue may take place from the collapse of the vesicles of a lobule, owing to the plugging of its bronchioles by a mass of tenacious mucus. The mechanism is like to that of a a *ball* valve; expiration can readily take place, but inspired air draws the mass tightly into the narrowing canal. The mechanical element enters largely into the production of catarrhal pneumonia, and thus marked physical signs will be found with the evidence of but slight local inflammation.

I may tell you that this disease is usually found in children under five years of age; that it is usually at its outset difficult to detect, occurring as it does as a sequence to bronchitis, and that of the capillary form, that it may have on this account either a very circumscribed area or involve both lungs to a great extent, or, again, be found in different portions of the same lung. It is usually located at a part farthest from the larger bronchial tubes, and very seldom does it present the solid mass of consolidated matter so circumscribed and involving a lobe, as does lobar or croupous pneumonia. Hence, these points are to be taken into consideration in the differential diagnosis of these two affections. But its course may be passive, as the result of hypostatic or passive congestions, and in that case it is usually a secondary disease, just as interstitial nephritis would follow passive congestion of the kidney, or interstitial hepatitis that of the liver, both possibly resulting from obstructive heart disease. You are all familiar with the pathology and diagnosis of the chronic catarrhal pneumonia of the apices in adults; the disease we are now studying is the same, only it is of an acute character.

We have, then, to deal with, in these cases, a general bronchitis, which affects the minute bronchioles, extending in a certain area, to the lining of the vesicles, which may be limited to one spot or may be found in both lungs; it may occupy a few scattered lobules or it may involve the greater part of or even a whole lobe. The inflammation extends to the intervesicular connective tissues, which rapidly reproduces itself, and becomes noticeable by giving rise to impairment of percussion resonance; vesicles collapse and increase the density of the mass, or they become choked with epithelial cells and detritus, and give areas of dulness. In the first stage you of course find great dryness of the mucous membrane and the accompanying physical signs; in the second stage, when the re-establishment of secretion has taken place, you will have râles of all descriptions, with the finest or the subcrepitant, over the areas of the disease. So profuse may this secretion become, and with such rapidity may it be produced, that a feeble child, unless aided by the most powerful expectorants and supported by the most stimulating treatment, may fairly drown in the accumulation within its lungs.

Probably not the least interesting part of the study to-day is that of treatment. We may divide it into two parts for consideration, the one *local*, the other *constitutional*. We also must bear in mind that it is to be modified by the three stages of the disease, the first with reference to the relief of the congestion and inflammation; the second to the rapid removal of the secretions from the bronchial mucous membrane; the third, the reabsorption of the intervesicular catarrhal products and the reinflation of the collapsed vesicles.

The morbid processes which we have just studied show us that we have to deal with tissue undergoing inflammation; but this inflammation brings with it increased supply of blood and the rapid production of new tissue, which latter will have to be reabsorbed after the inflammatory process is checked. The first indication that presents itself to you is most evident. You fulfil it by counter-irritants and revulsives. We use a poultice applied to the diseased side made of flaxseed-meal with a small quantity of mustard. This should be covered with oiled silk to prevent evaporation; it should be applied as warm as the child can bear it, and should be renewed every three or four hours. At the end of two or three days, of course depending upon the conditions of the case, the poultice may be replaced by a thick layer of cotton wadding. The whole chest should be rubbed at least twice daily with a stimulating liniment. I know of none better than

℞. Ol. Succ. ʒii.
Liniment. Saponis, fʒvi.,

which we shall use in this case. Turpentine and sweet oil may be used, or turpentine and fluid cosmoline. Should, in the earlier stages, the physical signs show an extensive involvement of the lungs or much capillary bronchitis, a few dry cups can be readily applied to the back before the poultice is used. A hot foot-bath containing mustard is also valuable, and should be repeated two or three times in the twenty-four hours.

I may say here that the child should be kept in a room of uniform temperature, especially so if you have found it advisable to give frequent hot baths instead of merely foot-baths, and in addition to the temperature of the room being kept at about 70°, you should keep the air moist by the constant slacking of lime. The object of this counter-irritation is not merely to relieve the lungs of congestion by promoting secretion from the surface of the body—increasing the activity of the skin's circulation, but also by reflex irritation to contract the capillaries of the bronchial tubes. I would advise you, also, at the onset, if the bowels are torpid and the tongue furred, to give a laxative. Castor oil is to be preferred for this purpose. The next indication is to promote secretion from the bronchial membrane, and thereby to relieve the congestion from within.

You may use for this purpose an alkaline fever mixture, obtaining what relaxation you can by the introduction of a nauseant or expectorant in small quantities. Should the membrane be very dry, and the febrile action high, as a basis I would suggest the following:

℞. Syr. Ipecac, ... ♏ x.
Liq. Ammon. Acetat, . . . ʒi.
Child one year, every three hours.

You can add to this spts. etheris nitrosi or liq. potass. citratis, if you wish. Then, again, with healthy children, when the capillary bronchitis is extensive, the cough dry and croupy, and the fever great, the *wine of antimony* may, in small doses, with great advantage, take the place of the ipecac until the severity of the symptoms subsides, that is, until secretion becomes established. In adults I have seen good results follow the use of jaborandi in such cases of bronchitis. I have not found it as reliable when used for children, and, as I used it in vain to throw off the false membrane in a case of diphtheria, and believe that in that case it weakened the

circulation, I have hesitated since to use it in children's practice. I believe you will get better results by the inhalation of steam, by the internal use of alkalies, and by counter-irritation, and at the same time run no chance of adding heart-failure to the already critical condition of your case. Should your little patients have a quick, bounding pulse, with high arterial tension, a condition more common in *croupous* pneumonia than in the disease we are now studying, the introduction of tinct. aconit. rad., ¼ gtt., repeated every three or four hours, under your own supervision, may soon bring about the required relaxation. Should, on the contrary, the child seem to be overpowered by the suddenness of the attack, be weak, with feeble circulation and no power of resistance, I would advise you to use the carbonate of ammon. (gr. I three or four times daily), and if necessary, use stimulants, as port wine or brandy, with it.

Catarrhal pneumonia is not of the high grade of inflammation so characteristic of the croupous or lobar variety. It is usually found in cachectic infants, in those that are rickety, or have phthisical parentage, or in the strumous, and therefore you will find it but seldom necessary to use depleting or debilitating treatment, but rather the stimulating and supporting measures from the start. It will be necessary to allay nervous irritability, and I know of nothing better for this purpose than potass. bromide, which, given in gr. ij. doses to a child of a year, has a quieting effect. You can administer it, or the ammon. bromide, at night.

To obviate the tendency to debility, you will be obliged to use quinia from the commencement—not given to the child for high temperature, but as a tonic in small and repeated doses. As you wish to keep the stomach in a condition to receive and digest milk—the only food for a child of this age—you should give the drug by suppository, using the *bisulphate* in doses of half a grain twice daily.

Bear in mind the increasing importance of food to sustain the strength of your little patient; if the child is not nursing, or refuses to nurse, you should see that at short intervals, perhaps every hour, sufficient milk, to which has been added barley-water, is given, to amount in the aggregate at the end of the twenty-four to the full complement of the child's meals when in good health. Albumen-water, whey, veal, chicken broth, or beef-juice, can be occasionally substituted, or, in fact, used instead, should the milk disagree.

I wish by no means to restrict you to the plan of medication I have thus sketched out; there are many other suggestions I could make, would time permit. The ammon. muriate, in the earlier stages, would usually be of great value as an expectorant; and you might find such indications as low vitality, or evident blood changes, that would necessitate the use of potass. chlorat.

Let us now anticipate the result in the case before us, and study for a while the treatment pertaining to the stage of convalescence. In a few days, a week at the most, free secretion will set in, the cough will become looser, the child's skin will become moist, and the febrile symptoms, instead of being constant, will develop a hectic character, with nightly exacerbations, gradually diminishing until the normal temperature is permanently maintained. The proliferated cells, and their débris, that are more or less within the vesicles, will be soon either absorbed or expectorated; these, with mucus, will be coughed up in quantity and swallowed by the child, and the mucus appear in the passages.

Frequently we find that at this time an excess of secretion takes place, and the child will be totally unable to relieve itself of it; you will have to watch this carefully. Add some stimulating expectorant to your treatment; use carbonate of ammonium freely (one gr. every three hours for a child of a year), and if you find upon auscultation that the râles are becoming more numerous, and the child shows signs of suffocation, give at once full emetic doses of ipecac or alum, and use the external applications of hot- and cold-water douches to the chest, alternately, to stimulate the respiratory function. I have frequently seen children saved from this threatened danger by using the most active treatment; and I remember a case of a young babe that occurred in this house some years ago, when life was saved after the child had become unconscious from asphyxia, due to profuse secretion from capillary bronchitis, by the alternate immersion into hot and cold baths, and free use of alum and brandy. Minute doses of atropia, or of belladonna, might be used with advantage to stimulate the respiratory centre.

The new intervesicular tissue will still remain for a while, firm and easily demonstrable by the physical signs. To its absorption you will have to direct your attention. You will now find it necessary to keep up a certain amount of counter-irritation, no longer by means of poultices and stimulating liniments, but by *iodine*, painting the surface over with a diluted tincture; not often enough to make the skin tender. Your main reliance will be placed in the following drugs: cod-liver oil, iron, quinia, and iodide of potassium. Let me call your attention to these *seriatim*.

There are many ways of administering cod-liver oil. You can have an emulsion made containing 50 per cent. of the oil. The following formula which I use is an excellent one:

℞. Ol. Morrhuæ, ... f℥iii.
Glycerinæ, ... f℥ss.
Pulv. Acac, ... ℥iij.
Aq. Cinnamomi, . . . f℥ijss.

This contains much less gum than is usually used, and requires more time and trouble in preparing, but I believe it agrees better, as it is more fluid, and has less tendency to constipate. The emulsion is certainly more palatable to children than the pure oil, and I think it is easier of digestion. I have used hydroleine of late in this hospital, a box having been sent me by Kidder & Co., of New York. In some cases it did well, but I did not find it superior to the ordinary preparations. In adult practice I think it at times a good preparation. I have seen one patient who was not able to retain cod-liver oil before taking it. The "pancreatic" emulsion of Savory & Moore (London) I am sure you will find an excellent preparation for children; its only disadvantage is that it is expensive, and when you have to use it for a length of time this has to be taken into consideration. Another good emulsion made by Dudley, containing pancreatine and lacto-phosphate of lime will serve you well, and it is much cheaper than the English preparations. But, after all, gentlemen, I think it better to advise you to have your emulsions put up from prescription, making only a small quantity at the time, and keeping the preparation of it under your own supervision—you will frequently find the oil emulsion useful as a vehicle for the administration of other tonics. My experience in this hospital leads me into saying that you will find, certainly among the poor, the addition of the lacto-phosphate of lime or the compound syrup of the phosphates of the greatest advantage. I have found that children will improve many times more rapidly when either of these is added to the emulsion, than when the latter is given alone, and I have attributed it partly to the very prevalent rickety diathesis. You can also add two or three grains of lacto-peptine to each dose.

Caswell, Massey & Co., of New York, have lately made an emulsion containing ½ gr. of quiniæ sulph. to the ℥ss. and gr. ij. of pepsine, and this I highly recommend to you, when your patients can afford it, for the

cases under consideration. Some of you know that the inunction of cod-liver oil is used most successfully in this hospital, and I need not delay to impress upon you its value in young babes in all cases when the oil is indicated.

As soon as your patient's stomach is in a condition to receive it, it is well to begin with small doses of iron. I need not tell you that the syrup of the iodide is the one most generally used. You can add to it your oil emulsion, beginning with five-drop doses and gradually increasing if it is tolerated. Frequently in its stead I have used potass. iodide, making use of the emulsion as a vehicle, using from one to two grains at each dose. I have of late been using the hydro-bromate of quinia instead of the sulphate with, I think, gratifying results. You can use it with the emulsion of oil. I have used the potass. iodide with great advantage by suppository in three- to five-grain doses, in cases when the indications were urgent for its use, and I have been led to attribute the good result to its use. It is necessary also to give attention to the excretion of the child at this time. The phosphate of soda has been recommended in these cases. You will find that its liver becomes torpid, whilst giving the oil, and that the so-called *bilious* spell will require either an occasional dose of castor-oil or one preceded by a small dose of calomel. The following powder is frequently used in this house for this purpose:

℞. Hyd. Chl. Mitis, . . . gr. ⅙
Pulv. Ipecac., ... gr. ½
Gum Acac, ... ℿ

Given at night with a dose of oil three or four hours later. Bear in mind the importance of attention to the skin; have the child thoroughly sponged at least once daily during the height of the attack, and morning and evening during its convalescence; keep it in a room of regulated temperature, but the air must be fresh and pure, and the sleeping-room well aired daily.

ORIGINAL ARTICLES.

GUNSHOT WOUND OF STOMACH—RECOVERY.

BY WALTER IZARD, M.D.,
OF LIBERTY, VA.

DECEMBER 27, 1881, Edward J., a small colored boy, aged about twelve years, shot himself with a toy pistol, into which he had managed to force a pistol cartridge of the calibre known as "*22 short.*" Within fifteen minutes after the receipt of the injury he was brought to my office, when his condition was as follows:

Pulse, fifty per minute, thin and feeble; extremities cold; surface bathed in a cold perspiration; eyes closed; tongue dry and pale; frequent vomiting; vomited matter consisted of clotted blood in considerable quantity, with a little mucus. Upon examination of the body of the patient, a small wound was discovered one inch below the ensiform cartilage, and one inch to the left of the median line. A probe cautiously introduced penetrated to the depth of three inches in a direct line towards the centre of the body. Gunshot wound of the stomach was diagnosed, and an unfavorable prognosis was made. The patient was conveyed to his home, put to bed, external heat applied, and a quarter of a grain of sulphate of morphia injected hypodermically. In a few hours, evidences of reaction appeared, when alcoholic stimulants were cautiously administered in small quantities *per orem*, with apparent benefit. These were carefully continued during the night, with sufficient opium to secure quiet.

No material change occurred until the 30th, when evidences of peritonitis became manifest, at first confined to a region extending from the point of the entrance of the ball to a point in the right groin two inches below the anterior superior spine of the ilium. This region was at first not more than one inch wide, and indicated, in the opinion of the writer, the course of the ball. From this strip of inflammation the peritonitis extended on all sides; the abdomen became tumid; the countenance drawn and anxious; the dorsal decubitus was constant, with the knees drawn up; the temperature reached 104° Fahr., and the pulse 140 per minute. The treatment consisted in the exhibition of opium to the point of maintaining constantly a condition of seminarcotization, with the continuous application of hop poultices to the entire abdomen, while sufficient nutriment was supplied by means of milk punch. The bowels showed a tendency towards diarrhœa, but were controlled with opiates. On the tenth day after the receipt of the wound, a decadence of the symptoms of active inflammation was observed, from which, gradually, convalescence and ultimately complete recovery resulted, so that at the present writing the boy is going about, apparently as well as ever before.

It seems evident, from the history of the wound, and of the order of the occurrence of the subsequent symptoms, that the ball must not only have penetrated the cavity of the stomach, but also have passed out of it, thus making a wound of entrance and one of exit in that viscus: a fact which, if admitted, at least doubled the chances against the patient; not only because two wounds are harder to heal than one, but because the wound of exit being, by a well-known law, larger than the wound of entrance, offered greater facility for the escape of the contents of the stomach into the peritoneal cavity. It is also to be remarked that, doubtless, no wound of the intestines occurred, and to be commented upon as most fortunate that this was so, for if such a wound had occurred, and this wound had admitted of the escape of fecal matter, as it surely would have done, it cannot be supposed possible that so favorable a termination would have been the result. It may also not be considered unworthy of remark that death did not occur from shock, when the immediate proximity of the solar plexus of nerves is considered, and when the frequent fatality of even slight injuries in that region is recalled.

POISONING BY CREASOTE.

BY FORDYCE GRINNELL, M. D.,
PHYSICIAN TO THE PINE RIDGE INDIAN AGENCY, DAKOTA.

BABY BREWER, a boy one year old, was given by his elder sister, in the absence of the mother, a teaspoonful of creasote. I saw the child about half an hour afterwards, and noted marked depression of the heart's action, great pallor, and an anxious expression of countenance, with an occasional hoarse, croupy cough and stertorous breathing.

The child obtained its nourishment mainly by

nursing, and a tenacious material, probably the milk partially coagulated by the creasote (as there was a strong odor of the latter), was expelled occasionally from the nose and mouth in attempts at coughing.

As it was not known that vomiting had taken place, the only emetic at hand, the fluid extract of ipecac, was given, and this was followed by castor oil, with the view of enveloping the poison which might be remaining in the stomach. Free emesis was produced, the material vomited having a strong odor of creasote.

As the breathing became more labored, and the signs of collapse imminent, aromatic spirits of ammonia was given, and mustard drafts applied to the feet. The pulsation which a little before could not be detected in the radial artery, now became perceptible, and the returning warmth of the body indicated a favorable reaction.

The indications now were to combat the inflammation, which, during the night, the extreme thirst showed to be already arising. Broken pieces of ice were freely given, which the child seemed to enjoy, and frequently indicated his desire for them. The thirst gradually became less, and on the morning of the third day I found the patient sitting up in bed and eating scraped apple. No further untoward symptoms supervened, and the child was a few days since brought to my office to be vaccinated.

I have noted this case, because it appears to me to be the duty of the physician to report all such cases for the mutual benefit of the profession.

The seventeenth volume of *Ziemssen's Cyclopædia* purports to be in the main a treatise on poisons, but no mention is made of creasote and its effects, the nearest approach being what is said under the head of carbolic acid. It is true that the action of these two drugs in poisonous doses is perhaps not very dissimilar, as the symptoms exhibited in this case, and those of carbolic acid poisoning, indicate.

On page 530 of the volume referred to, Boehm says of the symptoms of carbolic acid poisoning: "The breathing is described as stertorous by most observers, or if consciousness is not entirely lost as very laborious and dyspnœal. Well-marked general convulsions, up to the date of this, have never been developed in human beings, but are scarcely ever absent in experiments on animals."

And again: "In the earlier stages of the poisoning, the pulse is generally strikingly slow, later on it is generally much quickened. The repeated filling of the mouth with foam, observed in Jeffrey's and Hainsworth's cases, may be ascribed to salivation, which has been observed in most cases of poisoning which kill by asphyxia."

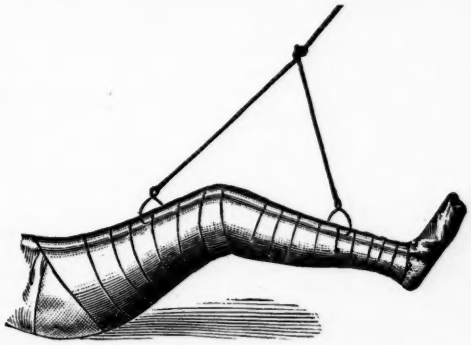
From these quotations, and a further perusal of Boehm's article, it will appear that the poisonous effects of creasote and carbolic acid have many points in common.

The filling of the mouth with foam or mucus, however, appeared to me in this case, as it accompanied acts of coughing, and presented strongly the odor of creasote, to be due to the action of the poison upon the milk. The milk ingested, perhaps, acted in part as an antidote, as the white of eggs given early after the reception of the poison might have done. Albumen would, perhaps, constitute the best antidote, of course to be followed at once by an emetic, in order to remove any of the remaining poison.

PROF. N. R. SMITH'S ANTERIOR SPLINT.

By EDW. BORCK, M.D.,
of St. Louis, Mo.

In The Medical News of January 14, 1882, appeared an article under "Hospital Notes:" "Treatment of Fracture of the Femur in the Hospitals of Philadelphia." Though there is nothing new in the methods depicted, nevertheless it is well and useful to bring them from time to time before the profession. The writer informs us that the dressing most widely employed in the hospitals of Philadelphia is one which combines the principles of extension and counter-extension with lateral support. I do not propose to criticise any method in regard to efficacy, but simply call attention to N. R. Smith's Anterior Splint, as the drawing of it given in The Medical News, *as well as in most of the text-books*, conveys an incorrect idea. It exhibits the suspending rope hanging down perpendicularly. This should not be so. The point of suspension should not be *vertically* over the leg suspended, but should be remote and so distant that a certain amount of traction may be obtained; without this factor, there can be neither extension nor counter-extension.



The cut here given will show the adjustment correctly.[1]

The same holds good for Dr. John T. Hodgen's splint. (Smith-Hodgen Wire Suspension Splint.)

In the treatment of fractures, all surgeons aim at extension and counter-extension; but let it be remembered, especially in *fractures* of the *femur*, it is *continuous* and *equable* extension we wish to secure; and, in the language of Dr. Hodgen, these factors can only be secured by suspending the limb; and I say emphatically, only by suspending the limb correctly. If the rope, when adjusted, hangs down perpendicularly, rest only is obtained; equal and continuous extension are not secured; and, without the latter, the result will not be very satisfactory with the suspension apparatus.

[1] A correct drawing can also be found in my monograph on "Fracture of the Femur," to which the reader may refer for description.

A YEAR'S WORK IN OVARIOTOMY.

BY WILLIAM GOODELL, M.D.,
PROFESSOR OF CLINICAL GYNECOLOGY IN THE UNIVERSITY OF PENNSYLVANIA.

FOLLOWING the custom of European ovariotomists, I here give the statistics of my last year's work in ovariotomy, and it is my purpose to do so every year. This paper does not, however, embody a twelve-months' work, but a ten-months' work, for, having attended the International Medical Congress, held at London, I was absent from home exactly two months of the year.

In the following cases, the letters S., M., and W. denote respectively single, married, and widow. The letters R. and L. mean the right and the left ovary, and the letter which precedes the other denotes the larger cyst. By the short incision is meant an incision between the navel and the pubes; by the long incision, one in which the incision has been prolonged to a point above the navel.

Number.	Medical Attendant.	Age.	Condition.	No. of Children.	Previous Tappings.	Place of Operation.	Date of Operation.	Adhesions.	Ovary Diseased.	Character of Tumor.	Incision.	Drainage.	Result.	Remarks.
1	Dr. Smith Fuller, Uniontown, Pa.	35	M			Home.	Jan. 22.	Omental, parietal, intestinal.	L	Large and semisolid.	Short.	None.	Death from Peritonitis.	The tumor was malignant; adhesions bad.
2	Dr. J. H. Chandler, Centreville, Del.	43	M	2	1	Private Hosp'l.	Jan. 29.	Omental.	L R	Medium polycyst.	"	"	Recovery.	
3	Dr. A. G. Coleman, Limerick Square, Pa.	44	M		2	Home.	Feb. 19.	Omental and pelvic.	R	Large polycyst.	"	"	"	Much ascitic fluid, and the womb greatly enlarged by multiple fibroids.
4	Dr. W. D. McGowan, Ligonier, Pa.	27	M	3	1	Univer'y Hosp'l.	Feb. 21.	None.	L R	Small.	"	"	"	
5	Dr. W. Sinkler, Philadelphia.	22	S			Private Hosp'l.	Mar. 2.	"	L R	"	"	"	"	Cyst of each ovary, and of left parovarium, removed, together with a fibroid body in right broad ligament.
6	Dr. L. D. Harlow, Philadelphia.	30	S		1	Home.	Mar. 9.	Omental, parietal.	L R	Large polycyst.	"	"	Death from Septicæmia.	At the time of operation was very ill from inflammation of the cyst, which was found full of pus; pulse, 140; temperature, 103°.
7	Dr. S. W. Mitchell, Philadelphia.	24	S		1	Private Hosp'l.	March 23.	Omental and pelvic.	L R	Oligocyst.	"	"	Recovery.	Right ovary enucleated from broad ligament.
8	Dr. G. S. Gerhard, Ardmore, Pa.	60	M	5		Univer'y Hosp'l.	March 29.	Omental.	L	Large monocyst.	"	"	"	
9	Dr. F. C. Sheppard, Philadelphia.	40	M	2	1	"	April 5.	Omental, parietal.	R L	Large colloid.	"	"	"	The cyst had burst previously to the operation.
10	Dr. J. R. Chandler, Centreville, Del.	40	M			Private Hosp'l.	Apr. 20.	None.	L R	Colloid.	"	"	"	
11	Dr. G. Mays, Philadelphia.	34	M		2	Home.	Apr. 21.	Universal.	R	Purulent.	Long.	Glass-Tube.	Death from Exhaustion.	A desperate case, in which pelvic abscess had occurred, matting everything together, and discharging through the bowel. For several days after operation fæces escaped through drainage-tube.
12	Drs. D. H. Agnew and W. Goodell,	42	M	2	1	"	May 10.	Intestinal.	R	Large oligocyst.	Short.	None.	Recovery.	
13	Dr. G. R. Meschter, Worcester, Pa.	49	M	9		"	May 14.	Parietal.	R L	Large polycyst.	"	"	"	
14	Dr. F. Schwartzlander, Doylestown, Pa.	32	M			Private Hosp'l.	May 17.	Parietal, intestinal.	L	Fleshy colloid.	Long.	"	"	A forlorn hope; bedridden for months, and greatly emaciated. Both tumors malignant; died on the table, while the wound was being closed.
15	Dr. A. Schæffer, Lewistown, Pa.	38	S			Home.	May 21.	Universal.	R L	Solid cheesy cyst.	"	"	Death from Shock.	

Number.	Medical Attendant.	Age.	Condition.	No. of Children.	Previous Tappings.	Place of Operation.	Date of Operation.	Adhesions.	Ovary Diseased.	Character of Tumor.	Incision.	Drainage.	Result.	Remarks.
16	Dr. T. R. Hayes, Bellefonte, Pa.	45	M	7	3	Univer'y Hosp'l.	June 2.	Omental, parietal, intestinal.	L	Solid colloid, 20lb.	Long.	None.	Recovery.	Many ligatures needed.
17	Dr. E. L. Duer, Philadelphia.	28	S			"	"	Extensive parietal.	L R	Large.	"	"	"	
18	Dr. J. Pittman, Tarboro', N. C.	50	S			Private Hosp'l.	June 7.	Covered by Brd. Lig.	L	Large uniloc.	Short.	"	"	Cyst had to be enucleated; womb gnarled by fibroids; two pedunculated fibroids removed.
19	Dr. J. Fay, Altoona, Pa.	61	M	8	1	Home.	June 18	Omental, parietal, pelvic.	R	Large.	"	"	"	
20	Dr. T. V. Crandall, Philadelphia.	62	W	2		Private Hosp'l.	Sep. 5.	None.	R L	25 lbs.	"	"	"	Womb gnarled with multiple fibroids.
21	Dr. J. Hearn, Philadelphia.	29	M	2		"	Oct. 9.	Omental.	L R	Solid fibr'd, 18 lbs.	Very Long.	"	"	
22	Dr. J. R. Haney, Camden, N. J.	50	M	3	1	Univer'y Hosp'l.	Oct. 20.	Extensive parietal.	R	65 lbs.	Short.	Glass-Tube.	"	An insane woman; very restless and uncontrollable.
23	Dr. R. W. Deaver, Germantown.	37	M	5		Home.	Oct. 22.	Parietal.	L R	Colloid.	"	None.	"	
24	Dr. E. W. Watson, Philadelphia.	50	W	7		"	Oct. 24.	Omental, parietal.	L R	20 lb. dermoid.	"	"	"	A tumor of twelve years' standing.
25	Dr. G. P. Yost, Loganville, Pa.	35	M	1	3	Univer'y Hosp'l.	Oct. 29.	Omental, pariet., pelvic, uterine.	R	30 lbs.	"	Glass-Tube.	Death from Exhaustion.	Patient very weak; a very formidable operation.
26	Dr. Lloyd, Yardleyville, Pa.	35	W	2		Home.	Nov. 5.	None.	R L	15 lbs.	"	None.	Recovery.	
27	Dr. Howard Kelley, Philadelphia.	40	S			Univer'y Hosp'l.	Nov. 7.	Omental, parietal.	R L	35 lbs.	Long.	Glass-Tube.	"	Womb enlarged by multiple fibroids; two pedunculated ones were also removed.
28	Dr. W. C. Simpson, New Brighton, Pa.	54	M	8		Home.	Nov. 12	None.	R	3 lbs. fibr'd.	Short.	None.	"	Solid fibroid of right ovary, with much ascites.
29	Dr. T. D. Dunn, Philadelphia.	36	M	2	1	Univer'y Hosp'l.	Nov. 14	"	R L	10 lbs. colloid.	"	"	"	
30	Dr. W. Goodell, Philadelphia.	27	M			"	Nov. 17	Omental, pelvic, intestinal, uterine.	L R	20 lbs.	"	Glass-Tube.	Death from Shock.	Both ovaries so implicated in tumor that it was impossible to tell the one from the other. A very difficult operation.
31	Ibid.	32	M	3		"	Nov. 25	Extensive and firm parietal.	L	45 lbs.	Long.	"	Death from Peritonitis.	Two cases of traumatic erysipelas were in the hospital at the same time.
32	Dr. B. F. Baer, Philadelphia.	20	S		1	"	Dec. 8.	None.	L R	15 lbs. colloid.	"	None.	Recov'y.	Both ovaries so adherent to womb that the bladder had to be dissected off, and the womb removed at its neck. She recovered from operation, and died on 31st day from pneumonia.
33	Dr. W. C. Dixon, Philadelphia.	36	M	2		"	Dec. 17.	Pelvic, uterine, and intestinal.	R L	20 lbs.	Short.	"	"	
34	Dr. M. H. Green, Philadelphia.	40	S			Private Hosp'l.	Dec. 31.	Intestinal.	L	15 lbs.	"	"	"	Cyst of left parovarium, with corresponding ovary flattened out in its walls.

My results do not show so well as some of the ovariotomists abroad, but this is owing to several very good reasons. In the first place my experience is not so ripe as theirs, and in no other operation in surgery does practice tell more than in this. Secondly, I have always felt that for a surgeon to decline to operate on a case of ovarian tumor, simply because it is not a promising one, is virtually the same thing as if he had operated on the case and had lost it. Acting on this principle, I have, no matter how desperate her condition, never refused to give the otherwise doomed woman her only chance for life. In this way I have been able to restore to life at least three women who had been abandoned by other surgeons, viz., cases XIV., XXI., and XXVII. But as a set off, by this rule of conduct I am compelled to report in my table three fatal cases, viz., Nos. VI., XI., and XV., which would otherwise not have appeared there.

Then, again, I have made it a rule always to try to remove a benign ovarian cyst, however adherent it may be, and always to complete the operation when once begun, however unpromising the result may seem. Hence, I have not an incompleted operation to report, since the operation once begun was always ended by the removal of the cyst. Nor have I, during the past year, in a single instance of ovarian tumor, for any cause whatever, abandoned the case after making an exploratory incision.

In the fourth place, I labor under the disadvantage, not only of having performed many of these operations in a general hospital, viz., that of the University of Pennsylvania, but also at the home of my patients, who lived at such a distance that I either could not see the woman again, or else was not able to pay her that close attention which her subsequent treatment demanded. I had also repeatedly to perform the operation in the country, with assistants who had either never aided at such an operation, or, indeed, had never even seen it. All these facts must be taken into consideration before a just comparison can be made between my results and those of more highly-favored operators.

The following analysis of my last year's cases will, I think, tend to verify some of these statements. For instance, I had twelve patients operated upon at their homes, with four deaths; thirteen in the general hospital of the University of Pennsylvania, with three deaths; and nine in my private hospital without a fatal result. Now, my private hospital is situated on high ground, and a patient there receives my undivided attention, because the building is so near my house that I can see her many times a day. Besides that, she has a skilled nurse to wait upon her, one who is experienced in the after-treatment of such cases. At the Hospital of the University the air is, of course, not so pure, and the patient receives but one visit a day from me. Again, her nurse is liable to be a general one and not a special one. Patients operated on at home are the worst off, because they often not only did not have a skilled nurse, but could not receive the close attention which is demanded after such an operation. For instance, out of the twelve patients operated on at home, six of them were not again seen by me, and two of them died. The other six were seen by me more or less frequently, and two of them resulted fatally. Still, statistics are notoriously misleading, and I am bound to own that some of these cases would have ended fatally whether operated on at home or elsewhere.

In the foregoing cases ether was the anæsthetic invariably given. I prefer ether, *ether fortior*, because it is the safest of all anæsthetics, and especially so when administered, as it often had to be in my distant cases, by a physician unaccustomed to its use, or by one who is very likely to forget the patient in his eagerness to watch the steps of a novel operation. Then, again, ether is not so liable as the other anæsthetics to be followed by stubborn vomiting.

All of these cases were operated upon under the spray, and every detail of Listerism was carried out, with the single exception that, in the place of the protective, the gauze and the mackintosh, the wound was dressed simply with salicylated cotton, covered by a roll of ordinary cotton-wool. I am very partial to this dressing. It is dry and antiseptic, and under it the longest wounds will heal by first intention, without the formation of any pus whatever. I do not remove the first dressing before the ninth day, and thus far I have at that time invariably found the wound wholly free from any smell. So long as I get such good results from Listerism, I shall not give it up, even in private practice. Nor do I see how it can very well be dispensed with in the foul air of a general hospital. Contrary to the experience of some excellent operators, I have not found that the spray causes such a rise in the temperature as to need the ice-cap. Of course, I have had to resort to its use, and on one occasion, in case V., I spent half the night in fighting a very high temperature by using two ice-caps: the one on the head and the other on the pit of the stomach. By daylight the temperature had fallen from 103.5° to 100.5°, and she eventually did well. My experience would lead me to say that the oftener I operate, the fewer cases of high temperature do I meet with. In my last eleven cases of ovariotomy, all of which were successful, I had to use the ice-cap in but two of them.

This question brings up another: that of the use of drainage. It will be seen that it was employed in six cases, four of which died. Of these fatal cases, three were operated on in a general hospital, viz., the Hospital of the University. Following Keith and Bantock, it has hitherto been my habit to use the glass drainage-tube whenever the oozing of blood cannot be stopped, and whenever a serous exhalation collects in Douglass's pouch. But, inasmuch as it interferes very materially with strict Listerism, I am disposed to look upon it with disfavor, especially in hospital practice. True, the three hospital cases in which it was employed were very bad ones. In two of them the womb was involved in the adhesions, and the women died from exhaustion, but the third one ought to have got well.

A few words with regard to some of my fatal cases may not come amiss, as they will show that in some of them the untoward result could not have been avoided. Case I. was one of nearly solid tumor, with many adhesions. The tumor looked so

suspicious that I brought home a fragment of it. This Dr. Formad examined, and pronounced it malignant. The operation was performed at the lady's home, three hundred miles away, and I did not see her again. She also lived four miles away from her physician. Her death was due to peritonitis.

Case VI. was one of suppurating cyst, in which the operation was forced upon me by the condition of the patient. At the time of the operation she had septicæmia. Her pulse ranged from 130 to 140, and her temperature from 102° to 103.5°. Altogether it was not a promising case.

Case XI. was a most desperate case. Dr. Mays, the attending physician, will, I am sure, agree with me, that it was, indeed, a very forlorn hope. A pelvic abscess had formed around the lower portion of the cyst, matting everything together, and had discharged into the rectum and vagina. The woman also had septic fever and a very high temperature, and was rapidly failing. Yielding to her urgent solicitations and to those of her husband, I allowed myself to be overpersuaded into operating. The adhesions were of the most formidable character, being pelvic, visceral, uterine, and omental. The hæmorrhage was alarming, needing many ligatures and the local use of hot water. During the separation of the cyst-wall from its pelvic attachments, the abscess was opened. This accident was announced by an audible whiff of very offensive gas, and by the entrance into the abdominal cavity of a quantity of stinking pus. Very careful cleansing was made, and a large drainage-tube was put in. For two days she lay pulseless and in a collapsed condition, her death being hourly expected. The drainage-tube meantime gave exit to broken-down blood and fœtid pus. On the third day, liquid fecal matter escaped in large quantities through the tube. This gave great relief, and her pulse now returned; but she never rallied from the shock, and on the seventh day died, her temperature never having reached 100°. The removal of this cyst was an error of judgment. With my present experience I would not have attempted it, but would simply have emptied the cyst, broken up all the child cysts, and stitched the opening to the abdominal incision.

Case XV. was another desperate case, operated on simply from a sheer sense of duty. The lady had been reduced almost to a skeleton by excessive pain and long-continued vomiting, and had been bedridden for three months. She also had a rectal stricture, which induced obstinate constipation. Her physician, Dr. A. Shaeffer, of Lewiston, Pa., will bear me out in the statement that it was a most unpromising case. Both ovaries were involved, and both had very bad adhesions, yet I have seen worse with uninterrupted recovery. The loss of blood was not great, but she suddenly died on the table just as the last stitches were being put in the abdominal wound.

Cases XXV. and XXX. were those in which the adhesions were universal and the operation very formidable. In each, more or less wounding of the womb took place. In the latter, both ovaries had so coalesced into one adherent mass that it was not possible to tell the one from the other.

Case XXXI. died, as I think, from hospitalism. The tumor was a large one, and the abdominal adhesions were so firm as to need the knife, but there was no good reason why recovery should not have taken place. In the private room next to hers, and in the room directly underneath, there were, at that time unknown to me, two cases of traumatic erysipelas, and I believe the fatal issue to be fairly attributable to the use of the drainage-tube, through which septic germs were conveyed into the abdominal cavity.

Case XXXIII. needs a more extended explanation than the brief one furnished in the table. The woman was a mulatto. Both ovaries were so fused to the womb that I had to dissect off the bladder, and remove the womb at its neck. The stump was brought out of the lower angle of the abdominal wound, and kept from bleeding by the wire clamp, which was daily tightened until it had cut its way through, and dropped off. She recovered promptly without a bad symptom. For three weeks she did well, the clamp having fallen off at the end of the first week, and the abdominal wound having closed up. She was, indeed, able to sit up in bed. Being now removed from a private room to the general ward, she caught a severe cold, and died from pneumonia on the thirty-first day after the operation.

This case, and one on which I operated year before last, are the only examples of ovarian cyst which I have met with in the colored race. But both women were light mulattoes, and would, therefore, be more exposed to the diseases of the white than to those of the black race. In each case, the cyst was fused to the womb, and the operation beset with many difficulties from visceral adhesions.

While opposed to tapping, as a dangerous expedient, my statistics will show that I am often compelled to yield my better judgment to the wishes of a patient, who is hoping against hope that she may thus escape the more dreaded operation. Apart from the well-known dangers attending tapping, such as hæmorrhage, inflammation of the cyst, or of the peritoneum, and the formation of adhesions, there is another danger not so well known, and that is the tendency to increase the solidity of the tumor. Repeatedly, after a first tapping, have I found the cyst almost wholly collapsing. At a second tapping, child cysts began to appear, and at a third, the tumor had become so solid as to demand a much longer incision than would have been needed in the first instance. By the term tapping I mean aspiration, for I have long ago abandoned the use of the old-fashioned trocar.

As I have undertaken, in this paper, to tell the whole story of my year's work in ovariotomy, I cannot, honestly, withhold one humiliating case of exploratory incision. On the 30th day of last October I was called into the country to see a lady, whose physician having tapped her with a trocar, and having withdrawn a "colloid fluid," very naturally inferred that she had an ovarian cyst. She was very fat, her legs and abdominal walls were also œdematous, and she was not only bedridden, but unable to lie in any other position than that on her left

side. The abdomen was greatly distended, and I discovered fluctuation, but no other signs of cystic disease than dulness on percussion. The diagnosis was doubtful, but as she clearly could not live long in her present condition, I determined to make an exploratory incision. When she was fully etherized we turned her on her back, and I had hardly begun the operation when she came nigh losing her life from the vertical pressure of the tumor on the diaphragm. Her breathing stopped, and she became pulseless and cyanotic. We instantly turned her over on her left side, and spent several very anxious minutes in resuscitating her. After this we kept her on her side, and as she still breathed badly, I hurriedly proceeded with the operation. After cutting through about four inches of fat, which bled very freely, I came upon a small opening, through which the omentum at once pouted out. Beneath and around this aperture my finger, and the fingers of two other physicians, apparently discovered nodulous structures and fibrous bands of adhesion, and we decided the case to be malignant. I accordingly closed up the wound, but on the following day she died from heart-clot, formed during the time of suspended animation. At a *post-mortem* made by two of the physicians, no abdominal tumor was discovered, but the liver and kidneys were "much enlarged," the omentum very fat, and the abdominal cavity filled with a "colloid fluid." It was also found that I had not penetrated the peritoneal cavity by my incision. My explanation of this is that the peritoneal end of the trocar wound had not only not healed up, but had been so stretched open as to admit a portion of omentum, which acted like a cork, in keeping the abdominal fluid from escaping, when I cut down upon it.

In conclusion, it seems to me that the only just way of rating an ovariotomist's success is to have each one publish yearly statistics, giving the fullest details of every case of completed ovariotomy, of every case of ovarian cyst on which he declined to operate, of every case abandoned after an exploratory incision, and of every case in which the operation was begun but not ended. In this way it may be unexpectedly found that the most successful ovariotomist, viz., the one who, in the aggregate, saves the most lives, is, in this truest sense, the one who shows the longest death-roll.

HOSPITAL NOTES.

PHILADELPHIA HOSPITAL.

(Service of Dr. EDWARD L. DUER.)

A CASE OF PULMONARY PHTHISIS IN AN INFANT SIX MONTHS OF AGE.

(Reported by W. A. EDWARDS, M.D.)

BABY H., æt. six months and four days. Child was admitted on October 16; was then a comparatively healthy-looking baby; its passages were frequent, slimy, and greenish, which condition soon passed away under appropriate treatment; the next demand for medicine was to prevent vomiting, which was easily controlled by the alkalies, and the child was then apparently healthy.

On about the 25th of October, the mother complained of the child's cough, which was worse at night, sometimes almost threatening suffocation. It was placed on a simple expectorant mixture, which afforded relief. I was called on the night of the 31st, in great hurry, hearing that the child was suffocating; found it in the nurse's arms, gasping for breath, cyanosed, and presenting a rapid, running pulse. I introduced my finger well down into the gullet and withdrew some thick, tenacious mucus, administered an emetic of ipecacuanha with the desired effect, after which the child was easy and slept comfortably.

In the morning a careful physical examination was made, and bronchitis detected over both lungs. A jacket poultice and expectorants were ordered together with carbonate of ammonia, whiskey, and digitalis, as the child was now rather weak. Continued this treatment until death, which occurred November 4, at 2 A.M.

Post mortem: Lungs.—Left lung presenting slight bronchitic appearances.

Right Lung.—Lower lobe congested, but containing air, upper lobe containing *numbers* of tubercles, and just opposite the right scapula, posteriorly, were found three cavities, each about the size of a three-cent piece; one was a very typical cavity, the other two could better be called excavations (vacûoles of the French writers), produced by the softening of small tubercular deposits.

The glands along the bronchi in this lung were converted into a firm resistant mass, resembling a portion of lung which has been the seat of tubercular infiltration; the enlargement was much greater in those glands which were seated externally to the lungs than of those which were imbeded in the pulmonary substance. Kidneys and liver normal, but anæmic. Spleen was slightly congested. Larynx normal and containing no ulcers, neither were tubercles found in the mesenteric gland.

Heart.—Right ventricle dilated and rather thinned. Left, contracted and slightly hypertrophied, although I am inclined to attribute this condition to the action of digitalis. The left ventricle contained quite a number of organized clots, which looked as though they had been present for quite a time.

The child's mother presents a cavity in the right apex about two inches in diameter.

The points of interest in this case are:

1. *The child's age.*
2. *The peculiarity of the disease in early life.*

1. In the examination of phthisis, in 46 cases under one year of age (West on *Diseases of Children*, p. 413), tubercle only was present in the chest in 16 cases; as to the degree of deposit, it was moderate in 3 cases, and considerable in 13. M. Cless, of Stuttgart, found vomicæ in only 9 cases out of 20, and he says, usually, the younger the child the less frequently is the occurrence of vomicæ. J. Lewis Smith (*Diseases of Children*, 2d edition) reports two cases in which there were no tubercles in the lungs. Sex does not appear to have any influence in the production of the disease. The majority of cases reported by Dr. Hennis Green were females; the majority of Rillet and Barthez's cases, males.

2. The peculiarities may be classed under the following heads:

1. The latency of the thoracic symptoms.

2. The entire absence of hæmoptysis. Sir James Clark, in his work on consumption, states that he does not remember to have met with any case in which hæmoptysis was present, but we may account for this from the fact that children do not expectorate, but swallow everything which may be brought up from the pulmonary mucous membrane.

3. The comparative slightness of the cough. It was slight, short, and dry, attracting attention by its fre-

quency rather than the discomfort which it occasioned the child.

4. The mildness of the colliquative sweats which so exhaust the grown person.

5. The ill-marked character of the hectic symptoms.

6. The fact that the tubercles were not simultaneously deposited; or, in fact, were absent in the majority of the child's organs.

In a case like the above, which runs a course so extremely rapid that many of its most characteristic symptoms have not time to manifest themselves, we are exposed to considerable risk of error, for the history of our little patient goes back only to a few weeks; evidences of impaired nutrition were almost altogether wanting, and the symptoms appeared to be those of an acute malady coming on suddenly.

As will be seen by the history, fluctuations took place in the child's condition, and the casual attack of bronchitis seemed to be the exciting cause which aggravated the pulmonary symptoms sufficiently to carry off our little patient.

MEDICAL PROGRESS.

Cantharides.—M. Albert Robin has published the results of a minute examination of the urine in a singular case, which was characterized by paroxysmal attacks of stranguary. The child was suffering from spinal caries, and the cause of the attacks was variously explained by different medical men who were consulted as vesical neuralgia, as the indication of lardaceous degeneration of the kidney, or as due to compression of the spinal cord. The real cause was only discovered by observing the coincidence of the attacks with the application of a mild cantharides ointment to keep open sores on the back. The peculiarities noted in the urine were: (1) a diminution in the chlorides during the crisis, and their increase the following day; (2) an increase in the phosphates during the crisis, so considerable that there was a spontaneous deposit of phosphate of lime and of ammoniaco-magnesian phosphate; (3) before and after the paroxysm there was a remarkable increase in the amount of lime and magnesia eliminated. At the commencement of the crisis, and even before it, there was a high degree of albuminuria, progressively diminishing until the close. During the whole paroxysm the urohæmatin was increased, and indican was present in considerable quantity. The total quantity of the urine was slightly diminished, but less so than in most cases of cantharidism. The urea was considerably increased. No blood-corpuscles or tube-casts accompanied the albumen.—*Lancet*, Feb. 25, 1882.

Relation of Meteorological Conditions to the Summer Diarrhœal Diseases.—Dr. S. C. Busey, of Washington, D. C., in the *Bulletin of the Philosophical Society of Washington*, contributes an interesting study on this subject, from which we make the following extract:

An analysis of the mortality statistics of these diseases leads to the following conclusions:

1. Diarrhœal diseases are far more destructive to infants than to adults.

2. They prevail almost exclusively during the warmest months of the year.

3. They are more prevalent in the region of this country north of the north line of the Gulf States, and east of the Rocky Mountains.

The first two conclusions are universally admitted; the third is not so generally recognized. Two additional propositions are suggested:

1. These diseases occur in groups, when the cases rapidly multiply during successive days for a week or fortnight, followed by an interval during which few or no cases occur.

2. These groups correspond with waves of continuous high temperature during day and night, which spread, at shorter or longer intervals during the summer months, over the northern climatic belt of this country, lasting from three to fourteen days, and varying in intensity at different times and in different years.

The first of these propositions cannot be established, because of the absence of statistical data relating to the beginning of the initial symptoms of the diseases; the second is proven by data supplied by the Signal Service Bureau. A comparison of these data with the mortality statistics shows:

1. That the month of July is the hottest and sickliest month of the year, most conducive to bowel affections, and most fatal to children under five years of age.

2. The epidemics of bowel affections of children, incident to the summer season, have their beginning nearly simultaneously with the first exacerbation of heat, which usually occurs in the latter half of June; and the maximum daily mortalities more frequently correspond with the maximum temperatures, which occur in periods of three or more days, at longer or shorter intervals during the summer months.

3. With the usual lowering of temperature and absence of excessive heat periods, which occur after the middle of August, the daily mortality declines.

4. The detrimental influence of summer temperature is intensified by sudden and acute elevations and falls.

5. Children under one year of age are most numerously and seriously affected.

Heat exhibits its deleterious influence in another and very important relation. It is one of the many conditions which, in conjunction, make up a season. A comparison of the statistics of the weekly mortality from diarrhœal diseases in the principal cities of the country, grouped according to latitude, will exhibit the gradual increase of these diseases with the gradual advance of the summer solstice northward until it reaches its maximum, during the period when all the elements which complete the season of summer are in their fullest activity; also a gradual decline with the return of the winter season.

The total movement of the wind is, perhaps, a more important influence than is generally believed. A comparison of the mortality data with the records of the monthly measurement of the wind, supplied by the Signal Service Bureau for the years 1875, 1876, 1877, 1878, 1879, and 1880, shows:

1. July is the month of greatest mortality and least movement of the wind.

2. The nearer the monthly movements of the wind approach uniformity, the less the mortality for summer diarrhœas.

3. Equality of climate corresponds with uniformity of and moderate or small movements of wind, and small mortalities.

4. Wide ranges of temperature correspond with large movements of wind, and high mortalities from diarrhœal diseases.

5. Weekly mortalities from diarrhœal disease increase correspondingly with advance of the summer solstice northward, increasing and greater range of temperature, and larger and more fluctuating movements of wind.

Relative saturation of the air bears no constant relation to mortalities. Moisture in relative excess to the heat of an impure and stagnant atmosphere is the condition which supplies the most satisfactory explanation of its detrimental influence.

Hæmatic Crises.—Under the name of "hæmatic crises" M. Hayem has described the alteration in the

constitution of the blood which attends the critical periods of those acute diseases that are marked by sudden defervescence. This alteration in the blood occurs so constantly, and with such well-marked features, that it merits the name of "crisis" as thoroughly as does the alteration in temperature. The essential characteristic of the hæmatic crisis is the transient accumulation of hæmatoblasts in the blood. Normally the proportion is one hæmatoblast to twenty red corpuscles, and when the conditions of blood-formation are normal this proportion is nearly constant. During the course of acute diseases the number of hæmatoblasts is decreased, and then suddenly at a certain period undergoes a rapid increase, while that of the red corpuscles remains nearly the same. In forty-eight hours the number of hæmatoblasts is double. Twenty-four hours later, however, it presents a notable fall, and gradually sinks to its original figure. If the changes are represented in a graphic diagram, the variation in the number of hæmatoblasts takes the form of a cone with a very sharp apex. This hæmatic crisis is never wanting in these diseases, and is quite comparable to that which is indicated by the temperature. It commences towards the end of the malady, usually at the moment when the temperature begins to fall, and attains its height on the day on which the temperature is for the first time normal, when defervescence is complete. In the eruptive fevers, such as scarlatina and measles, in which a febrile temperature may continue after the defervescence which follows the eruption, the hæmatic crisis attains its acme at the end of the partial defervescence which follows the eruption. Whatever the original number of the hæmatoblasts and of the red corpuscles, the abnormal proportion attained at the period of the greatest accumulation of the latter is always the same. The average is one to seven, and it only varies between narrow limits —from one to six to one to eight. The red corpuscles are at a minimum at the period of the commencement of the hæmatic crisis, when the hæmatoblasts begin to accumulate in the blood. They increase in number during the course of the crisis, especially in proportion to the return of the hæmatoblasts to the normal number. The new corpuscles, however, contain less hæmoglobin than do the adult corpuscles. Hence the value of the corpuscle (*i. e.*, its average richness in hæmoglobin), which was unchanged during the course of the disease, lessens considerably during the new formation of the elements of the blood, the fresh elements remaining for a time imperfectly developed. The blood thus presents the characters of a slight degree of anæmia, and so remains during the whole of the convalescence. The hæmatic crisis is the indication of the attempt at reparation of the blood which occurs at the end of acute diseases. During the course of these affections, the process of blood formation is hindered, but when the morbid cycle arrives at its close, there is the sudden attempt at reparation, commencing by a great increase of new red globules—*i. e.*, hæmatoblasts—and soon these imperfectly developed elements are transformed into red corpuscles, which only very slowly acquire their due proportion of hæmoglobin. The phenomena are similar to those observed after considerable loss of blood, which is followed by an augmentation in the hæmatoblasts, preceding an increase in the red corpuscles.—*Lancet*, Feb. 25, 1882.

CURABILITY OF UTERINE DISPLACEMENTS. — Dr. GEHRUNG holds:

1. That cases of displacement of the first class (acute) may be cured by almost any means or method that may be tried. Even here permanent cures are not the constant termination.

2. That cases of the second class (sub-acute) are occasionally cured by surgical operations; some get well (apparently or really) by themselves, if left alone; others are benefited by pessaries as temporary supports, and therapeutical means. The resulting cure is frequently not due to the means employed.

3. That cases of the third class (chronic) are rarely ever permanently *cured* by any of the known means. Among those cases that can be relieved by operations, some will be permanently cured, by far the greatest number only temporarily. Pessaries seldom effect a lasting cure; but worn constantly at first, and interruptedly at a later period, may render the patient perfectly comfortable for lifetime, almost equal to a cure.

4. Uncomplicated ante- and retroversions are the displacements which are most easily removed. Pessaries are the principal means for their removal, sometimes cure. Surgical and other means are usually unnecessary, and rarely successful.

5. Retroflexions, if uncomplicated, are next in the scale for easy replacement. They yield best to pessaries, but, as a rule, will return soon after their removal. If complicated with tissue metamorphosis or otherwise, retroflexions are indeed very troublesome, though they can mostly be overcome by pessaries and manual assistance. On removal of the pessary the displacement rapidly returns. All other means are unreliable.

6. Anteflexions are still less amenable to curative treatment than the aforementioned displacements. Though cures are claimed in consequence of bilateral and posterior sections, by tents, and by intra-uterine stem pessaries, the flexion is not cured, only the stenosis is lessened. Vaginal pessaries offer the best success with the least risk. Highly gratifying results may mostly be obtained by their judicious use. Where weakness from atrophy or anæmia or subinvolution is the cause of the flexion, electricity, rest, posture, massage, local and general medication are the means to be relied upon. Pregnancy, *if possible*, often diminishes the subjective morbid symptoms, rarely ever cures the disease.

7. Latero-versions, true and false, are troublesome displacements. They can, however, as a rule, be conquered by appropriate pessaries. All other means are powerless.

8. True latero-flexions are happily very rare, and almost incurable. False (or pseudo) latero-flexions, *i. e.*, lateral rotation of ante- and retroflexions, are amenable to the same treatment as the primative displacement upon which they depend, but with somewhat modified ante- and retro-*version* pessaries. So-called *flexion* pessaries are a dream of the past.

9. Retroverted anteflexion (probably a congenital defect) cannot be replaced by any means except pessaries. This is, if possible, a more troublesome displacement than even pseudo latero-flexion. If the relief of the accompanying symptoms by a partial restoration to normal shape and position could be called a cure, this displacement might be considered as generally curable by pessaries, while all other means appear to be useless.

10. Prolapse of the first degree, when uncomplicated by diseases or tumors, and dependent, as it is, on relaxation of the supports *en masse*, may be relieved or cured by rest, posture, general and local medication, electricity, massage, etc. The simultaneous use of an appropriate pessary should never be omitted.

11. Procidentia or prolapse in second and third degree may be temporarily (rarely permanently) cured by operations, or permanently relieved (probably never completely cured) by pessaries.

12. Ovarian displacements can generally be reduced and retained by well-constructed pessaries, with complete relief of symptoms, provided there is no structural disease in the displaced ovary. If such disease is present, the relief will be in inverse ratio to the disease. Surgery alone promises a cure (?) by extirpation of the diseased ovary.

13. Rectocele and vesicocele must be met surgically if complicated by laceration of the perineum; if not so complicated, pessaries offer the best result.—*St. Louis Courier of Med.*, March, 1882.

The Extraction of Cataract in the Unopened Capsule.—Pagenstecher claims the following advantages for this method, as seen in an analysis of 117 cases:

1. A perfectly clear pupil is obtained.
2. Iritis, especially plastic and recurrent iritis with all its consequences, is never observed.
3. Vision once restored is not liable to subsequent deterioration by secondary opacity of the capsule, and secondary operations are not required.
4. A greater portion of perfect vision is obtained than by any other method.
5. Hæmorrhages, especially recurrent hæmorrhages, are much less frequently observed.
6. Dazzling, due partly to slight irritation of the iris, partly to diffusion by the remaining capsule, is less frequent during recovery, and never occurs at a later stage.—*Ophthalmic Review*, March, 1882.

Successful Porro's Operation in a Woman with Osteomalacia of the Pelvis.—Boyer reports the case of a patient who had been three times delivered, the last time with forceps, and who showed the characteristic modifications of the pelvis due to osteomalacia. Porro's operation was performed at the end of pregnancy. After opening the abdominal cavity, the uterus, after Müller's plan, was rolled into the wound and opened after ligation of the cervical portion. Compression of the pedicle, which was treated externally with a 2½ per cent. chloride of zinc solution, was made by Billroth's ecraseur. The case was successful for both mother and child.—*Centralb. f. d. Med. Wissen.*, Feb. 25, 1882.

Suppression of Urine after Ovariotomy.—At the meeting of the Clinical Society of London on February 10, Mr. Knowsley Thornton brought forward a case in which suppression of urine was threatened several times after ovariotomy; on each occasion packing the arms in cold wet towels relieved the symptoms, and the patient made a good recovery, and has remained in perfect health since. The following is a brief outline of the case: J. W., aged thirty-nine, married, and mother of two living children, the youngest seven years and a half old, was admitted into the Samaritan Hospital in October, 1880. *History.*—Never strong; during the last seven years has had three stillborn children and two miscarriages. Since last miscarriage has had irregular and too frequent menstruation. Abdominal tumor first noticed early in last pregnancy, September, 1879. A few weeks before admission, Dr. Pierce, of Denbigh, tapped the tumor, and removed twenty-four pints of greenish fluid. *Condition on admission.*—Looks older than her age, and has a waxy skin; kidneys act badly, and skin is dry and hard; no albuminuria. Ovariotomy performed November 4, 1880, and tumor of right ovary removed, weighing, with contents, twenty-eight pounds. Operation of average difficulty. A good deal of sponging necessary, and occupied an hour. Temperature and pulse rose rather rapidly, and on the day after the operation the urine was scanty and dark, and the kidneys were very irritable. Digitalis and citrate of potash were given, and next day the urine was free, and loaded with lithates. On the fourth day the kidney irritability returned, and the temperature and pulse rose again; sympathetic vomiting came on; and on the sixth day, the condition appearing critical, the arms were bound and packed in cold wet towels, which were kept wet with iced water. In twelve hours all bad symptoms had disappeared. The towels were allowed to dry, and in five hours the patient was as ill as ever. The towels were wetted again, and were kept applied for forty-eight hours, during which time the patient appeared quite well; and the wound was dressed for the first time, and found soundly healed, and all the sutures were removed. The towels were removed; but during the day the kidney symptoms and sickness gradually returned, and they were reapplied. Temperature and pulse remained unaffected, but the kidney symptoms at once yielded. On the eleventh day they were again removed. On the twelfth, the temperature being normal, the patient was allowed to get up. A few days later she went home; and Dr. Pierce writes that she is now in better health than she has enjoyed for some years.—*Lancet*, Feb. 18, 1882.

Erosion of the Innominate Artery in Consequence of Secondary Diphtheria of a Tracheotomy Wound.—This case, occurring in a boy nine years old, eleven days after the operation of tracheotomy, differs from the cases supposed to be analogous which have been reported by H. R. Bell, J. Wood, and Körte, in that the erosion was caused by extension of the diphtheritic process and not by pressure of the cannula. In this case, reported by Gnandinger, the tube had been removed several days before and the autopsy showed a cavity lying in front of the trachea, from which the tissue-destruction extended into the thoracic cavity. The left wall of the innominate artery was here of a greenish color, and was perforated in two spots of the size of a poppy-seed.—*Centralb. f. d. Med. Wissen.*, Feb. 11, 1882.

Surgical Uses of Kangaroo Tendon.—A paper was read on this subject by Mr. Girdlestone, at the meeting of the Royal Medical and Chirurgical Society on February 14. The author stated his belief that for tying large vessels in their continuity, the long even tendons from the tail of the kangaroo were as strong as the silk ligature, caused no ulceration in the coats of the vessel, and had all the valuable qualities of catgut, without its defects. The tendons also make excellent sutures, resisting the effects of purulent discharges for a long period. A reef-knot does not slip or become loose. Where there is no suppuration the tendon coalesces with the tissues, and in suppurating wounds, though softened, they are found still to hold together at the end of eight days. The tendons were previously immersed for some weeks in carbolic oil, and entire tendons only were used. They have been employed in ovariotomy and in vesico-vaginal fistula, and held till union took place. In plastic operations—hernia and varicocele—the tissues have readily healed over them. A medium-sized tendon is so strong that it is difficult to break it with one's hands, and it is uniformly strong in its entire length of from twelve to eighteen inches. Tendons can be hardened for use as sutures by immersion in a half per cent. solution of chromic acid, after which they can be also used as drains for wounds. In their preparation they should not be removed from the tail *en masse*, but one at a time and without force, as, if split longitudinally, they cannot be relied on, and should not be used. Every diameter that is required is attainable, so that there is no occasion for splitting, neither should two or more tendons be twisted together, as it destroys their flattened form. On removal from the recently killed animal they should be cleansed in water, and afterwards in a carbolic-acid solution, and then dried, and can be so preserved, or in a five per cent. carbolic oil, as most convenient, to be again steeped in a watery solution of carbolic acid before use.—*Lancet*, Feb. 18, 1882.

THE PARASITE OF LEPROSY.—The observations of Hausen on the bacillus of leprosy, confirmed by Heiberg, Bidenap, and Winge, have recently received additional confirmation from MM. Cornil and Suchard. These investigators found that when a portion of leprous tissue was teased out in water, numerous bacilli were seen in active movement. In sections stained with methylaniline the characteristic cells of the diseased tissue, and the endothelium of the bloodvessels, were seen to contain rods and elongated spheroids. The cells of the epidermis covering the leprosy-nodules contained no parasites, which may account, the authors suppose, for the rarity with which the disease is propagated by contagion. In one case, in which the liver was found in a condition of hypertrophic cirrhosis, the bacilli were found in the newly-formed cells present in the interlobular connective tissue, and were also found in some of the hepatic cells.—*Practitioner*, March, 1882, from *Annales de Dermatologie et de Syphiligraphie*, 2d Series, vol. ii., No. 4.

TOXIC ACTION OF SALIVA.—M. GRIFFINI has undertaken to repeat the experiments of MM. Pasteur and Vulpian on the toxic action of saliva injected under the skin, and has communicated an article on the subject to the *Archivio per le Scienze Mediche*, t. v. He obtained both pure parotidean and mixed saliva, and injected both fluids beneath the skin in rabbits. He believes that pure parotidean saliva is perfectly inoffensive, that ordinary mixed saliva filtered through porous plates, so as completely to prevent the passage of microbia, does not produce any local gangrenous changes, but a general infection of the blood, resembling in all essential respects septicæmia. He has satisfied himself that it is the saliva, and not the microbia that it contains, which produces the septicæmic condition. Mixed unfiltered saliva contains much more toxic constituents, due probably to commencing putrefaction, or to fermentation in the buccal cavity; hence, when this is subcutaneously injected, gangrenous complications occur with necrosis of the tissues and ordinary septic accidents due to the resorption of gangrenous products. M. Griffini considers that his experiments prove that the toxic action of saliva is due to a non-organized ferment.—*Lancet*, Feb. 18, 1882.

AGARICUS IN THE NIGHT SWEATS OF PHTHISIS.—Mr. J. M. YOUNG classifies the results of his observations as follows:

1. Night sweating becomes proportionately lessened according to the amount of the drug administered; and, if sufficient doses be given, becomes effectually checked or prevented, according to the time of administration.

This was observed to be the absolute rule in all moderate cases of phthisical night sweating where it was tried, and in one case, where the sweating was colliquative, agaricus brought the sweating within moderate limits. In other cases of sweating not dependent on phthisis the drug was found to work well; indeed, its most notable effect was observed in the case of a patient who had had sweating of the right side of his body and right leg persistently at night for eight months, and in which a dose of ten grains stopped the symptoms for a night almost at once.

In the quickness of its action, agaricus resembles atropia. Like atropia, too, the effect is not permanent.

2. The effect of the drug against sweating is not more marked than its effect in promoting sound sleep, and relieving troublesome cough, especially of phthisis. This is the most notable fact to the patients themselves, a gradually increasing feeling of drowsiness following its administration in most cases.

The antihydrotic and soporific effects of the drug are probably distinct from one another, and not to be related as cause to effect, since, in some of the cases observed, sweating was always complained of as occurring *during* sleep, the body being covered with perspiration on awakening. Cessation of cough may, however, be the result of the soundness of sleep.

3. Strict investigation seemed to show that the drug has considerable influence in reducing the temperature, in cases of phthisis at least, where the fever is unstable, as much as two degrees of a fall having been observed within half an hour after administration of 1-12th of a grain of agaricine. Such a marked result was not always obtained by repetition of the experiment in different cases; but the fall observed in this way averaged 1.4°, and had its expression in a relieved feeling on the part of the patient.

Along with the effect on temperature, it may be noted that the rate of the pulse becomes usually reduced to a corresponding degree, but this effect has not been invariably noticed.—*Glasgow Med. Journ.*, March, 1882.

DELPHINIUM AJACIS.—Dr. BENVENUTI has recently published the results of his researches upon the virtues of *delphinium ajacis*. (*Giorn. Ital. delle mal. Ven. e della Pelle.*, Aug., 1881.) A cold acetic acid infusion of the flowers in many cases of phtheiriasis pubis was very efficient in destroying parasites and ova. In several examples of intractable ulcerating bubo, lint, soaked with the above infusion, brought about speedy cicatrization. An aqueous infusion of the dried flowers brought about similar results in instances of phagadenic ulcers, virulent wounds, and adenitis seen in prostitutes. From his experiments, the author draws the following conclusions: The flowers of the delphinium possess an insecticide action. They are to be preferred to other remedies of similar action on account of cheapness and absence of smell. They have a marked anæsthetic action, are excitant, rubefacient, astringent, and antizymotic. The author thinks this remedy has many points of resemblance to carbolic acid and iodoform.—*Practitioner*, March, 1882.

BATHS FOR THE NEWLY-BORN.—Dr. F. WINCKEL, of Dresden, (*Centralb. f. Gynäkol*, January 7, 1882), makes the novel suggestion of keeping certain newly-born children permanently in warm water. This he considers more useful than rolling them in cotton-wool, applying warm bottles, and keeping them in warm rooms. The following abnormal conditions are mentioned as being suitable for the permanent bath: 1. Children born between the 28th and 36th weeks; 2. Children born asphyxiated and weak from flooding during labor, or who have accidentally lost blood from the stump of the cord; 3. Where there is disease or fretting of the skin; 4. In emaciation, to prevent bed sores. The author has employed this treatment successfully in cases such as those above mentioned, and gives details of temperatures and results.—*Glasgow Med. Journ.*, March, 1882.

TOTAL EXTIRPATION OF THE UTERUS THROUGH THE VAGINA.—Dr. F. MARGARY reports this case, which was operated upon after the method of Billroth. Patient was affected with epithelioma of the cervix. As there was an extreme retroversion of the body of the uterus, it was first luxated posteriorly and brought into the vagina through an incision made in the utero-recto-vaginal septum. The parts were ligated laterally, and the uterus carefully dissected out, and removed entirely, complete hæmostasis being obtained by numerous ligatures. A large drainage-tube was inserted in the vagina, and Lister treatment pursued. The operation lasted nearly an hour, and the woman's condition gave hopes of a successful result.—*Gazzetta Degli Ospitali*, Feb. 26, 1882.

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SATURDAY, APRIL 1, 1882.

DRUNK OR DYING?

SUDDEN unconsciousness is the objective evidence of several different morbid states. An unknown man of the middle, or after-period of life, falls and remains unconscious in the street, and the question which the bystanders have to decide, is—has he had an attack of cerebral hæmorrhage, of alcoholic intoxication, or of opium narcosis? These questions are the more perplexing if the breath of the unconscious man smells of alcohol, or of laudanum. If of the former, he is trundled to the station-house, tumbled into a cell, and left to die or recover as the case may be. If of the latter, attempts to pour emetics into the stomach are made, apomorphia is administered subcutaneously, or the stomach-pump is introduced, it may be into the trachea, and the lungs pumped full of chalk mixture, as happened a few years ago in a London hospital. The mistakes made as to the causes and conditions of sudden unconsciousness are so disastrous, that the police and hospital physicians concerned, suffer greviously in reputation. Any physician may, indeed, be called upon to give an opinion in such a case. It may, therefore, be opportune to discuss the subject as fully as our limits will permit.

The differentiation of the several morbid states, causing sudden loss of consciousness, is by no means easy. In exceptional cases there are no symptoms which may not be possessed in common. In the absence of a correct history, in all doubtful cases, it were far better to assume the worst to be true, than to diagnosticate drunkenness and consign the unfortunate subject to a prison cell. The diagnosis of acute alcoholismus is the most common error. An attack of cerebral hæmorrhage may be precipitated by a glass of whiskey. The breath under such circumstances will have an alcoholic odor. A distinction is to be drawn between a fresh alcohol smell on the breath and the fetid odor of the drunkard's breath, due to the ethers and other products of the oxidation of alcohol in the system. The breath of an old toper has something distinctive about it which an experienced man ought to recognize. An opium odor may also be present in the breath of a man dying of cerebral hæmorrhage. For some of the prodromes, preceding an apoplectic seizure, laudanum may have been taken, and this, like alcohol, may have precipitated the rupture of a miliary aneurism in the brain. Obviously, in the absence of some specific information, it is unsafe to trust to so fallacious a test as the odor of the breath.

In perfectly typical cases, the pupils may afford exact indications, being minutely contracted in opium poisoning, dilated or unequal in hæmorrhage or concussion, and rather dilated in alcoholismus. In cases of hæmorrhage into the pons or medulla the pupils may be minutely contracted; in alcohol narcosis the pupils may be contracted or unequal, and in opium narcosis, they may be dilated or unequal. The state of the pupil may, or may not, therefore, be of any value in coming to a decision. The position of the eyes and head—the conjugate deviation—may be of great service in some cases. In cerebral hæmorrhage the eyes and head are turned towards the side on which the hæmorrhage has occurred, and from the paralyzed side. In alcohol and opium narcosis, the head takes the position given to it, and the eyes are directed forward.

The appearance of the face is not without value as a means of differentiation. In opium narcosis, the face is pale, rather sunken, and covered with a cold, clammy perspiration. In cerebral hæmorrhage and in concussion, the appearance varies; it may be pale if the hæmorrhage is large; or flushed and full and the facial veins swollen. In acute alcoholismus, the face is turgid and purplish, with venous congestion and cyanosis, the lips swollen and purple, the conjunctiva injected, and the eyelids puffy. The flapping of the cheeks, and the snoring inspiration are characteristic of cerebral hæmorrhage, and do not occur in opium or alcohol narcosis. In the latter the respiration is heavy, often noisy, and labored, and slow; in opium narcosis, the respiration is very slow, very shallow, and has a rather sighing character. The pulse characteristics correspond to the respiratory. In cerebral hæmorrhage it is apt to be slow and full, sometimes irregular; in alcohol narcosis, rather slow and small; in opium narcosis, slow and small, or very rapid and small.

The condition of the skin is very significant. In cerebral hæmorrhage the skin is rather warm; in

opium narcosis, relaxed, white, and covered with a clammy sweat; in alcohol narcosis it is usually warm and moist, and rather flushed. In all these forms of unconsciousness, if complete, the reflexes are abolished, and the muscles are in the condition of relaxation. Lying thus, an inert mass, the only signs of life are organic—respiration still continues feebly, the heart is slowly and imperfectly carrying on the circulation. Obviously, the means for exact determination of the condition causing unconsciousness are not very significant. Yet if all the points above mentioned are carefully investigated, a correct conclusion will usually be reached. The wise physician, will, however, abstain from hastily pronouncing a judgment, which may be overruled in a few hours, and will rather preserve a "masterly inactivity," and await the discovery of those facts in the history of the case necessary to the formation of a correct opinion. Meanwhile, he may employ such rational measures of treatment as the state of the case will warrant. The subcutaneous injection of atropia will be indicated if pulse and respiration are obviously failing, and the respiratory muscles may be stimulated to renewed effort by faradic excitation, and by mechanical respiration. The stomach-pump should be applied with the care necessary in all cases in which the faucial and laryngeal reflexes are in abeyance. In the absence of a suitable stomach-pump, an ordinary rubber tube may be converted into a stomach tube. Fluid at a proper elevation in a vessel connected with the stomach tube, will readily flow into the stomach, and then by depressing the end of the tube it will be converted into a siphon. At the earliest practicable moment, some urine should be drawn off, and hastily tested for alcohol, for morphia, etc. In some instances of profound insensibility from poisons, the urine has been quickly and satisfactorily tested physiologically by injecting under the skin of an animal, for example, the domestic cat.

THE STATE BOARD OF EXAMINERS OF NEW YORK.

THE need for some higher standard of medical education than the prevailing one, and the necessity for some more conclusive evidence of fitness for assuming the responsibilities of practice than is now afforded by the mere possession of a medical diploma, are strongly shown by the present movement in New York in favor of the establishment of a State Board of Examiners. The principle involved, the advantages not only to the community and to the profession, but even in the long run to disappointed candidates, of an elevation of the attainments which should alone confer a right to practice, are so obvious as barely to require statement. The community is benefited because human life is rendered safer, and is protected from the carelessness or incompetence of half-educated physicians; the profession is aided because its truly worthy members will find competition reduced, and success not so far removed or so uncertain; the rejected applicants will be profited by it because their unfitness for their chosen career is disclosed at its outset, instead of after the lapse of valuable years and the loss of irretrievable opportunities.

That these facts are strongly impressing themselves upon the minds of the profession, and that their recognition is working great good, are shown by the progressive changes in the curricula of medical schools over the whole country—the lengthening and grading of courses, the establishment of preliminary examinations, the increase of laboratory facilities, the augmented importance of clinical teaching, and many other improvements, often made by instructors at a sacrifice of time, labor, and profit, all pointing in the same direction, and testifying to the same general truth.

The laity, too, are becoming interested, as they naturally should, preventable illness and death being the gravest of all sources of national feebleness. One of the great New York dailies has recently seen fit to devote a large space to a review of the opinions of prominent physicians as to the desirability of some such legal action, upon which point it may be remarked, in passing, they were unanimous. It is safe, then, to say, that the common sense of both the profession and the public assents to the proposition, that if increased restrictions of the power to confer the legal right to practice medicine were possible without infringement of individual or corporate privileges, they would prove beneficial to every one concerned.

It is by no means so easy, however, to point out the exact methods by which these restrictions may legally and equitably be established. For many years, probably beyond those allotted to the present generation, the superabundant supply of more or less imperfectly prepared physicians will doubtless be kept up. Colleges with few advantages for clinical teaching—the corner-stone of all future medical education—and with every inducement from a pecuniary standpoint to facilitate graduation, will hold their charters and pursue their present methods, modifying them only under the irresistible pressure of public opinion. Young men, designed by nature for mechanics or merchants, for statesmen or soldiers, will persist in mistaking their vocation, and will still vainly imagine that the possession of a degree and the ability to manage disease are associated and inseparable conditions.

Neither of the above assertions as to colleges and students is to be wondered at. Human nature is much as it has always been. Voluntary and immediate sacrifice of comfort, of position, or of profit,

for the sake of principle, or even for a doubtful increase of material advantage in a remote future, will ever be of exceptional occurrence. As to the student, we need most of us but to recall our own imperfect conception of the duties and responsibilities of the profession during our college-years to comprehend and at the same time to commiserate his rashness and unfounded self-confidence.

Preliminary examinations somewhat diminish this source of evil, but their adoption rests with the colleges themselves, and cannot be forced upon them.

Under these circumstances, the remedy is naturally sought for in some power which shall be external and, in a legal sense, superior to the medical schools; and in New York it has taken the shape already alluded to, viz., the proposed establishment of a board of impartial and competent examiners, whose certificates shall afford the only legal authority to enter upon the practice of medicine. The objections, however, are numerous and weighty, and cannot all be said to have been rebutted.

Can the State, having conferred, with the power to grant diplomas, the right to practice, in equity revoke or recall that right? Can such a board as is talked of be so constituted as to pass impartially upon applicants of all the so-called "schools" of medicine? Can an examination upon the principles of medicine be considered to be sufficiently comprehensive omitting disputed points, such as questions of therapeutics? Can a sufficient number of competent men be obtained, who are not occupied in medical teaching, and who are thereby free from all suspicion of personal bias? If there are such men, is there any probability that, under our present political system, they would receive or retain the appointments?

All these questions are essentially connected with the subject, and should be carefully and critically examined into. We do not think it possible at present to answer them satisfactorily, but that the results aimed at by the bills transmitted to Albany are greatly to be desired, and that the movement is the consequence of a genuine need felt by the profession and the community at large, we earnestly believe. It is to be hoped that, in a matter which so closely affects the social and scientific standing, and the general welfare of the reputable physicians of the country, all steps will be taken cautiously, and only upon well-assured foundation of law and justice, in which event there can be small doubt that the influence of the entire profession will make itself felt in approval and support.

WOMEN AS DRUGGISTS.

At the recent commencement of the Philadelphia College of Pharmacy, we notice, with pleasure, that the Junior prize was awarded to Miss Grace Lee Babb, of Eastport, Md. We learn that there were two female students in the College during the past session. It is encouraging that fifty per cent. of their number took prizes.

Of all the many new avenues opened of late to women for an honorable, appropriate, and, it may be, a lucrative occupation, we know of none that promises better results than that of pharmacy, and our only surprise is that they have not taken it up long ago and in large numbers. Accuracy, neatness, cleanliness, politeness, these are all the requisites besides a knowledge of pharmacy. This last surely no one will claim is beyond the ability of the average woman, while the former are perhaps more peculiarly womanly virtues.

Moreover, the experiment has been tried, and tried with success. For a number of years the prescriptions at St. Mary's Hospital, we learn, were made up by the junior resident, but for some years past they have been in the entire charge of one of the sisters of the hospital. The order that came out of chaos, the cleanliness out of uncleanliness, the neatness out of disorder, were simply marvellous, while so far as the prescriptions are concerned, they are better compounded than before, and the expense from waste and mistakes, and carelessness and ignorance, is greatly lessened.

Whether women will ever be able to establish and conduct a large drug-store as a business venture, we do not know, nor do we care to discuss it. It is especially as ordinary retail druggists and as prescription clerks that we think their services would not only be useful, but welcome. We are glad to see the liberal spirit of the College of Pharmacy in opening its doors to them, and we hope that these two students are but the forerunners of many others. The Woman's Medical College could establish such a Department of Pharmacy, with but little expense, and it is well worth their while to consider the expediency of doing so. Their Professors of Chemistry and of Materia Medica are already provided, together with an excellent chemical laboratory. A Professor of Pharmacy and a pharmaceutical laboratory would be the only additional facilities necessary. We believe that such a department would be self-supporting almost from the very start, and would be soon an important source of income, to say nothing of its chief purpose as a school for women druggists.

SEWER-AIR AND ITS REMEDY.

If the belief in the potency of sewer-air as a carrier of disease-germs is not clearly established by direct and positive proof, there is no disposition nor reason to renounce it, nor dare we do so with safety, without more convincing proof of its fallacy than has hitherto been presented. It seems reasonable to suppose that the effluvia arising from sewage, which

contains more or less of the material favorable to the development (under suitable conditions frequently present in sewers) of the morbific elements of certain zymotic diseases, are capable of producing these diseases when, under favorable circumstances, they are brought in contact with the human body. We do not know positively the manner in which sewer-air becomes impregnated with these minute particles of living matter, or germs; whether by the ordinary agitation of the sewage, by means of organic dust detached from the occasionally dry walls of the sewers, or by the ascentional power of the watery vapor, or by the bursting on the surface of the liquid of bubbles of decomposition, is still a matter of conjecture. Nevertheless, with the mass of circumstantial evidence in our possession, there is not much room for doubting the presence of zymotic matter in the air of sewers, and the possibility of its transportation by means of gentle currents.

Excluding the special agency of sewer-air in transmitting the specific germs of disease, there still remains the indisputable fact that it is a hurtful mixture, which cannot be breathed in confined apartments without serious detriment to the general health. Hence the necessity, irrespective of this or that view of the *modus operandi* of causing disease, of securely and permanently excluding sewer-air from our houses. This is mainly to be accomplished by interposing a barrier, in the form of a serviceable trap or by means of an air-disconnection, between the drains of the house and the common sewer, and by thorough and constant ventilation of the entire system of house-pipes.

In adopting these essential requirements of modern house-drainage, we must not lose sight of the fact that it is equally important that the sewers shall be constructed and managed in such a manner as to prevent them, as far as possible, from becoming a source of noxious exhalations. As contributing to this object, it is essential that there shall be a prompt and rapid discharge of the sewage, and a free circulation of fresh air throughout the entire length of the conduits. The sewers should be constructed of the best materials, and in the best manner; they should be water-tight, and not larger than the actual necessities require; their interior surface should be perfectly smooth, so as to facilitate the flow of sewage, and prevent the deposit of sediment; and their shape and size should be such as is best adapted to the character of the flow, and as will permit of efficient flushing. Ventilation is best secured by properly made, free, and direct openings in the street, a plan which is recommended for its simplicity, and which, by the test of experience, has proved to be the one most entirely reliable and satisfactory.

By the rigid application of these principles in the construction and management of house-drains and common sewers, the air in these conduits will, in a great measure, be robbed of its noxious properties, and the protection of the inmates of houses, thus guarded, be rendered almost complete.

STATISTICAL RESULTS OF THE OPERATION FOR EMPYEMA.

IN the tables furnished by Dr. Moutard-Martin of his operations for empyema, we find some points of interest if not really new. The most favorable condition for the success of thoracentesis, is that form of empyema consecutive to subacute pleurisy—for of 9 cases of this kind, all were cured. Second, in respect of success, are those examples of purulent pleurisy, produced by the penetration of hydatid cysts into the thoracic cavity: of 8 cases of this variety of empyema operated on, 7 were cured and 1 died. Purulent pleurisy consecutive to the serous form presents less favorable results, for of 42 cases, 30 recovered and 12 died. This is, also, the most usual form of disease requiring the operation of thoracentesis.

All the cases of tubercular origin, whether of tubercular pleuritis, or of secondary pleurisy excited by a pleuro-bronchial fistula, or by perforation of a cavity, proved fatal. It may be desirable to state, for the purpose of comparison of forms, that there were 7 cases of empyema tubercular in origin. The cases due to pleuro-bronchial fistula without tubercle, were much more favorable—for of 19 cases, there were 12 recoveries and 7 deaths. There is little doubt, we think, that these experiences correspond closely to those which obtain in this country.

DR. JOHN S. BILLINGS has an excellent article in the January number of the *International Review* on the late International Medical Congress held in London. He reviews briefly the chief topics of discussion, including the germ theory, vivisection, Pasteur's researches, medical education, etc. After all the chief value of such assemblies, as he well points out, is in the personal acquaintances and conversations to which it gives rise; "for," as Sir James Paget aptly puts it, "in the mart of knowledge he that receives gains, and he that gives retains, and none suffer loss." With equal aptness, and a like happy diction, Dr. Billings concludes his paper thus: "Although the great Congress is gone it is not like a flame blown out, but like a handful of seeds scattered."

A BANQUET, presided over by Dumas, was recently given to Chevreul, the venerable chemist, on his ninety-sixth birthday. The Café Riche, at which the banquet was given, was elaborately decorated with flowers, in honor of Chevreul's skill as a horticulturist, and to typify his valuable work in the art

of tinting artificial flowers—an art which owes its remarkable development to his chemical researches. Chevreul has long been celebrated for his discoveries in the chemistry of fats. It is an interesting fact that this remarkable man is still engaged in lecturing on chemistry and in conducting original investigations, although he has now entered on his ninety-seventh year.

SPECIAL ARTICLE.

DISINFECTION.

I.

Aerial.

Disinfection is concerned with two objects, chiefly: with the removal of offensive effluvia; with the destruction of morbific germs; and these objects are nearly related. The removal of foul odors involves the treatment of the organic matters producing them, and the destruction of germs includes the disinfection of the solids, liquids, or gases in which they are contained, or with which they are associated. The relation of foul odors to disease production is rather æsthetical than consequential and causative. Nevertheless, the frequent, especially the constant, inhalation of the gases of putrefaction—the compounds of sulphur and phosphorus with hydrogen, the volatile fat acids, etc.—does slowly impair the vital forces, inducing a form of anæmia and chronic gastro-intestinal disorders. An obvious distinction between causes that impair the general health and disease-germs must be kept in view. Thus, sewer-gas, the product of the putrefaction of animal and vegetable matter, may slowly impair the quality of the blood; but if it be the medium for the conveyance of scarlet fever, diphtheria, or typhoid germs, these forms of disease respectively are engendered by the inhalation. When the declaration is made that some specific malady has been produced by sewer-gas, the writer confounds this distinction and attributes to sewer-gas results due to the accidental presence of some specific germ.

Into the sewers or other receptacles of human excreta and of decomposing animal and vegetable matter, the discharges from typhoid, scarlet, diphtheria, and other specific diseases, are conveyed, and with the gases produced by the putrefactive decomposition, are carried up the germs of these diseases. Around the persons of infected subjects, the air may be full of specific germs. Morbific materials, dried and pulverized, are distributed by the air in all directions. Thus the various disease-producing germs, whether unorganized ferments or minute organisms, may reach and infect susceptible individuals. We are warned against foul odors, because they are repugnant to one of our senses, but they may give notice of the approach of a more serious danger. The air we breathe may contain morbific principles, whose presence is unannounced, and known only by the effects which will follow.

Disinfection must be aerial, as well as against fluids and solids which emit foul odors, and which contain the germs of diseases.

Aerial disinfection includes the treatment of the air of the sick-room, of the house, and of sewer or cesspool connections. The agent diffused in the air of the sick-room must be effective and at the same time without injurious effect on the invalid. As a rule, the pastiles burned merely substitute a more agreeable smell; but an exception to this must be admitted in *benzoin*, as *benzoic acid* is an antiseptic of some value. The *vapor of iodine* is efficient, and easily employed. Some tincture or crystals of iodine, placed in a saucer on the mantel or table, is vaporized slowly. The compounds of sulphur and phosphorus, with hydrogen, are decomposed; watery vapor is also decomposed, hydric iodide formed, and oxygen, as active oxygen or ozone, set free. The bleaching effects of the vapor of iodine have been attributed to the active oxygen. Hydric iodide (hydriodic acid) is, also, a powerful reducing agent. Iodine may combine directly with organic substances, forming a compound of great permanence, and strongly resisting change. These facts indicate its value as an aerial disinfectant. It may also be used to disinfect the excreta of the sick, some tincture of iodine being added to the evacuations as soon as passed. It is, however, too expensive a disinfectant to be employed generally—for any other purpose, indeed, than as an aerial purifier, limited to the sick-room.

Chlorine acts like iodine. It is an active and powerful oxidizing agent in the presence of water, setting free oxygen as active oxygen or ozone, and combining with hydrogen. The offensive effluvia, composed largely of the compounds of sulphur and phosphorus with hydrogen are similarly decomposed, the hydrogen seized by the chlorine, and the associated agent set free. Chlorine is much more powerful than iodine, and cannot be liberated in the apartments of the sick, freely, without injury. It should be generally known that chlorine gas is apt to light up pneumonia when inhaled too abundantly. There are facts indicating that an amount of the gas, not sufficient to cause much distress of breathing, will excite an inflammation of the lungs in some subjects. It should also be known that as a bleaching agent, for which, as all the world knows, chlorine is much employed in the arts, it affects injuriously fabrics of wool and silk. Chlorine is an effective deoderizer and disinfectant, and not only offensive odors, but minute organisms are destroyed by it. It is esperially useful as an aerial disinfectant, but in the sick-room must be cautiously used. Four ounces of chloride of lime (hypochlorite) may be dissolved in a gallon of water, and cloths, flannel preferably, hung up in the apartment. In this preparation the chlorine is very loosely combined, and is displaced by the carbonic anhydride (carbonic acid) of the air, and so slowly that the air of the apartment does not contain at any time an injurious quantity. The powder may be at once added to any of the excreta—a tablespoonful to an ordinary stool or urinary evacuation. When a large quantity of chlorine gas is used to disinfect an unoccupied apartment, all woollen or silk materials and metals should be removed, the windows and doors closed, and several pounds of "chloride of lime," acted on by an acid, the gas allowed to con-

tinue in action for twenty-four hours. Another method for procuring the gas in quantity, is by the action of hydrochloric acid on peroxide of manganese, aided by heat. Over a quantity, say two pounds of peroxide of manganese, on a plate, may be poured eight ounces of hydrochloric acid, and the mixture placed on a hot brick.

A safer, cheaper, and probably a more efficient disinfectant, is *sulphurous acid gas*. Although entirely irrespirable in a pure state, it has been inhaled without injury diluted to a degree in which it is still irritating to the breathing organs. It is very destructive of disease-germs and of minute organisms, and it decomposes the gaseous products of vegetable and animal decomposition. One part in 10,000 parts of air destroys plant-life. Owing to its strong affinity for oxygen, it is a powerful reducing agent. In this property, we find the source of much of the disinfectant and deodorizing power. Sulphurous anhydride is readily procured by burning sulphur. The quantity liberated in any apartment may be regulated by the sensations of discomfort—the metallic taste, the constriction of the fauces, the headache, etc. The destruction of germs can be insured only by filling the apartment, or house, with the gas, the windows and doors closed. It is useful, in the event of a contagious disease appearing in a house, to generate such a quantity in the sick-room as can be inhaled by the patient without risk, and sufficient to completely fill the halls and other apartments for a half-hour at a time, daily. A pan of live coals and some sublimed sulphur are the only materials required. The clothing, bedding, and utensils may be effectively disinfected by arranging them suitably in a closed apartment, and keeping it filled with the gas for several days. It should be remembered, of course, that sulphurous anhydride bleaches by the formation of colorless sulphites.

Carbolic acid, alone, or in combination with iodine tincture, is employed as an aerial disinfectant. The acid (common will do) may be diffused through the air of the sick-room by gently warming it in a suitable vessel, or strips of cloth moistened with it may be hung up at various points. A neat way to diffuse it through the atmosphere of the sick-room, is by means of the atomizer, a one-per-cent. solution being pulverized. The acid and tincture of iodine mixed, may be treated by these methods. Aerial disinfection by carbolic acid has a questionable value. It is little more than the substitution of one bad odor for another. In the strength in which only it is tolerable, doubts may be well felt as to its power to impair the vitality of germs or ferments.

As *active oxygen or ozone* is produced in the course of the reactions with chlorine and iodine, the disinfectant and deodorizing powers of these agents have been referred to this peculiar substance. Ozone may be readily generated for the purification of the sick-room. A stick of freshly-scraped phosphorus is placed in a glass jar containing some water, but not enough to cover the stick. In the process of the oxidization of phosphorus, ozone is liberated in considerable quantity. Such a preparation placed in a secure position, and freely exposed to the air of the apartment, will accomplish the object efficiently, and with the minimum of distress to the patient. The recent researches of Binz on the physiological actions of ozone have disclosed some interesting and important results, not, however, connected with its disinfectant property, but they warrant the assertion, that in the quantity inhaled by the patient no deleterious effects will be produced. If this agent performs the part now assigned it in the bleaching effects of chlorine and iodine, it must be a valuable aerial disinfectant for the sick-room.

REVIEWS.

PERCUSSION OUTLINES. By E. G. CUTLER, M.D., and G. M. GARLAND, M.D., pp. 65, and 9 plates. Boston: Houghton, Mifflin & Co., 1882.

This book, in the words of the preface, is intended to teach students the anatomical position of the thoracic and abdominal viscera in the living subject, and to portray such boundaries of those organs as are accessible to percussion. Chapter I. discusses method in percussion, and gives excellent practical rules for the position of the patient, and for the operation, and defines the boundaries of the regions. The rest of the text is occupied with the regional anatomy and the physical diagnosis of the thorax and abdomen. The plates are outlines of the organs, and of percussion boundaries, copied from Weil. The authors, indeed, say that this manual is a condensed abstract of the German literature on this subject, which they have verified for themselves. It is an excellent manual, and one that we can honestly commend to instructors and students. Typographically it is well executed, as is the habit of the Riverside press.

A TREATISE ON FOOD AND DIETETICS, PHYSIOLOGICALLY AND THERAPEUTICALLY CONSIDERED. By F. W. PAVY, M.D., F.R.S., F.R.C.P., Physician to Guy's Hospital, etc. *Second Edition*. 8vo, pp. 402. New York: William Wood & Co., 1881.

The first edition of this excellent work, the author informs us, was exhausted in less than a year. The American edition now before us is the second. The work is a comprehensive one, and every subject is handled with the characteristic thoroughness and fidelity of the author. After an introductory chapter on Force—on the dynamic relations of food—he discusses the origination of food. Then follow chapters on alimentary principles, their classification, relations, chemical and physiological, and uses in the economy. Pavy maintains the postulate that the human machine simply utilizes the force furnished it, as does any machine, and is itself not consumed, except in the ordinary process of wear and tear. He holds that nitrogenous matter supplies "the essential basis of structure," and the non-nitrogenous—the hydrocarbons (fats), and the carbohydrates (starch, sugar, etc.)—supply the materials of force production. For a long time, the theory of Liebig, that the various activities of the body—nervous, muscular, glandular, etc.—were resultants of the oxidation of the tissues themselves, was universally held. Very recently, indeed, Flint, Jr., maintained that his study of the excretions of Weston, the pedestrian, supported the view of Liebig, but Pavy gives the opposite interpretation to the same state of facts. Since the conclusive demonstrations of Traube, but few physiologists have adhered to the theory of Liebig, and the present state of scientific opinion is all but unanimous in favor of that view which is maintained in this work.

Although the nitrogenous foods are devoted to the development and to the repair of the tissues, they may by oxidation furnish force, but in doing so they are split up into urea, an excrementitious nitrogenous substance, and into a material for force production, which is non-nitrogenous. Similarly, the non-nitrogenous foods may be utilized in tissue formation. The main purposes of the two classes of foods, are, however, to repair waste of tissues, and evolve the necessary force for the performance of the various bodily functions.

The work contains a full account of all the substances used as foods, animal and vegetable; fruits, beverages, including alcoholic, beer and wine, etc. The preservation of food and the principles of dietetics are discussed in special chapters. The subject of the therapeutical applications of various diets is also considered, but, on the whole, not so fully as is desirable. A few formulæ for the preparation of diets for the sick are given, but this part of the work might be enlarged usefully. Finally the work concludes with the dietaries of the various London and Provincial hospitals.

From this sketch the reader will be able to form some conception of the value of the book. It is an important member of the series. The type is old and much worn, and the paper poor and thin. Better typography could be offered only at a higher price we suppose, and hence they must not grumble who choose to buy cheap works.

SOCIETY PROCEEDINGS.

RHODE ISLAND MEDICAL SOCIETY.

Quarterly Meeting, March 16, 1882.

The regular quarterly meeting of the Society was held March 16, in Lyceum Hall, Providence. About sixty Fellows were present. The President, Dr. Chas. O'Leary, occupied the chair.

The Secretary, Dr. Geo. D. Hersey, read the records of the last quarterly meeting, after which a committee was named by the Chair to nominate

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION.

This committee afterwards reported the names of the following gentlemen, who were elected Delegates: Drs. J. H. Eldridge, G. P. Baker, Ariel Ballou, Otis Bullock, W. E. Anthony, E. T. Caswell, Eugene Kingman, G. W. Jenckes, Job Kenyon, H. E. Turner, J. H. Morgan, F. B. Carpenter, A. A. Mann, and G. A. Pike. It was left for the President to appoint four additional delegates, and to fill all vacancies.

The report of the committee, appointed at a previous meeting, to lay the matter of

EXPERT TESTIMONY

before the State Legislature, was next called for. Dr. Job Kenyon, Chairman, said there was nothing definite to report, but he would offer the suggestion that a petition be drawn up and signed by the Fellows of the Society, addressed to the General Assembly of Rhode Island. He further remarked that the object in view was to secure legislative enactments regulating the fees of physicians giving testimony as experts before the Courts, and to remove the odium now attached to expert testimony. It was voted that such a petition be drawn up by the same committee.

THE REPORT OF THE BOARD OF CENSORS

was then presented by Dr. S. S. Keene, recommending to fellowship the following gentlemen: Gardner T. Swarts, M.D., Joseph N. Baretta, M.D., and Albert M. Knapp, M.D., all of Providence. The two first named were elected to membership, but the name and recommendation of Dr. Knapp, were referred back to the Board of Censors.

Dr. James Morton, of Providence, who had applied for membership, submitting to the Board of Censors a diploma from the "United States Medical College, of New York," signed by Drs. R. A. Gunn and J. H. Day, was not recommended for election, as the Board had no knowledge of the existence of such a medical school or faculty.

Dr. E. T. Caswell expressed his approval of the course taken by the Censors in their exercise of discrimination in the matter of diplomas, and said there had been great readiness in the past to accept anything in the shape of a diploma that might be presented.

Dr. S. S. Keene announced that at the next meeting of the Society he proposed to move that the By-laws be so amended as to require every applicant for fellowship to present himself in person before the Board of Censors, and undergo a satisfactory examination.

Dr. Ariel Ballou, of the Board of Censors, rose to explain why this change was desirable and necessary, and said that heretofore it had been regarded as sufficient if an applicant possessed a diploma emanating from some medical college recognized by the American Medical Association, but that experience had shown that application is frequently made by those having this qualification who are not worthy of membership.

Reports of cases were next called for. Dr. Lloyd Morton, of Pawtucket, described a

CASE OF HYDRONEPHROSIS,

in a woman sixty-two years old, who had been under his observation for several years. The passage of biliary calculi had been suspected from time to time, and cancer of the uterus was diagnosticated in February ult. Ten days before her death there was complete suppression of urine for forty-eight hours. She died in a state of uræmic coma. The *autopsy* revealed the presence of several calculi in the gall-bladder—two of large size, an inch or more in diameter, and very dense; also, that the right kidney had entirely disappeared, a sac containing serum being formed in its place. A *renal* calculus, the size of a large bean, was found firmly lodged in the right ureter, distant from the bladder about one-third the length of the ureter.

The interesting point in the case was that a renal calculus of that size could have passed so far along the ureter, and become impacted, without causing symptoms of its presence. The only time such symptoms were known to have existed was in December and January of the years 1869 and 1870, when there was lancinating pain in the right inguinal region, and shooting down the thigh.

Dr. E. T. Caswell, of Providence, reported a recent

CASE OF LITHOLAPAXY,

performed by himself, on a man sixty years of age, in rather delicate health, and who had been obliged to use a catheter habitually for the past six years on account of prostatic enlargement. The operation was done early in January last. A Thompson's lithotrite was used, and great difficulty was experienced after grasping the stone, in freeing it from the bladder-wall, so as to crush it, not, apparently, from its excessive size, but owing to the saculated condition of the lining membrane of the bladder. A curved tube, No. 26, French scale, was introduced, and, by means of Bigelow's evacuating apparatus, sixty-two grains of phosphatic calculus were removed. About an hour was consumed, and, although the anæsthetic (sulphuric ether) was well borne, it was thought best not to continue its use longer at the time, owing to the general condition of the patient and the time occupied, although it was certain that fragments of stone still remained in the bladder. For

two or three days subsequent, there was slight tenesmus, but no chill or fever. Orchitis developed two weeks later, but the patient had been subject to similar attacks before. In February the operation was repeated, and one hundred and seventy-four grains more of stone were removed, without the slightest unfavorable after-effects, and the patient soon regained his usual health and strength.

DR. CASWELL also called attention to a

FIBROID TUMOR OF THE UTERUS

he had recently removed, per vaginam, from a patient thirty-five years old. The growth weighed 1½ pounds, was 5½ inches long, 3½ inches in its broadest diameter, and about 2 inches thick, being narrower and thinner at one end than at the other. The smaller end of the tumor had presented at the os, and the attachment to the uterine wall embraced the whole of the distance from the os to the fundus, and one-eighth the circumference of the uterine cavity. Thompson's spoon-saw was the instrument used, and no hæmorrhage followed the operation, hot carbolized water being injected at once. The patient, who was under the care of another physician, did very well for three weeks, when septicæmic symptoms appeared, and she died at the end of five weeks. The time of the operation was less than an hour.

DR. WILLIAM H. PALMER, of Providence, next read a paper on

CRIMINAL RESPONSIBILITY.

The writer first defined law and crime, and said the "law presupposes, on the part of its subjects, a capability of receiving and understanding its requirements." He said: It is not easy for jurists to decide always who are competent to commit crime and who are really irresponsible on account of insanity, and the great question now asked of the medical profession by the courts is in regard to who are competent, in the eye of the law, to commit a criminal act and who are not? There is too much pseudo-philanthropy brought to bear on this subject. It is well known how often a criminal escapes punishment simply by the cleverness of his counsel in raising a plea of temporary insanity. This should be condemned as a mere sensational effort to prevent the punishment of the guilty. If a man *knows* that when under the influence of liquor he is liable to be quarrelsome and dangerous, and yet deliberately gets into a condition of intoxication, he is as morally responsible for any crime he may commit, while in that state, as though he did the deed after due deliberation and with wilful intent.

In regard to suicide, it is found to be most common in countries like the United States and France, where there is the greatest license to the individual, in thought, speech, and action, while, on the other hand, in Russia and Sweden, countries ruled by a monarchy, suicide is more rare.

The accessibility of means, the profession or pursuit of the individual, and a craving for notoriety after death, will exercise great influence in determining the means of death employed.

To protect the rights of society was said to be the highest object of law; and to protect the rights of the individual, the highest object of man.

The assassin of President Garfield was alluded to in these words: "The miserable Guiteau, undoubtedly insane in the opinion of most alienists, is at least disordered in mind and moral nature by his supreme vanity and egotism, and diseased by his private and social vices, yet the forethought and deliberation with which he assured the success of his crime, prove him capable of a sound reasoning process relative to its commission. Having wilfully debased his own nature, he is none the less responsible for the crime, which was the legitimate outcome of its debasement."

If there was that same irresistible impulse to enforce the punishment of crime that there is to defend it, on the ground of irresponsibility, there would be less crime committed. There is now a premium on crime which society cannot afford to pay. Based on the fact of an insane ancestor, or a recorded outburst of excessive anger, a person has a plenary indulgence to commit crime without the fear, or hardly the possibility, of punishment.

When juries shall be instructed to render a verdict of "guilty and insane;" when the responsibility of insane criminals is accepted, and penal institutions are provided for such a class, then the verdict of "not guilty," "by reason of insanity," will no longer be returned; there will be a more just conception of human accountability; and a more heroic exercise of the human will being demanded, will be exercised.

It was voted to refer Dr. Palmer's paper to the Committee on Publication.

DR. F. B. FULLER, of Pawtucket, then read a paper on

MANUAL DILATATION OF THE OS UTERI.

Among the conditions which may render rapid dilatation necessary, there were mentioned hæmorrhage, nausea and vomiting, chorea, albuminuria, contracted pelvis, and pelvic tumors. The necessity may not appear till labor is well advanced, and may then become very urgent. The various other means suggested for rapid dilatation were next alluded to by the writer. The hot vaginal douche is uncertain and tedious; rupture of the membrane may not be followed by delivery for three days; galvanism is not practicable. There are at least nine different metallic dilators and three kinds of water- or air-bags recommended; but their use is, in many cases, of doubtful efficacy. Inserting a flexible instrument between the membranes and the uterine wall is safe and often advisable.

There is no reliable oxytocic in the way of medicines. Manual dilatation may be a bold procedure, but there are several others now resorted to by the profession which formerly would hardly have been attempted or sanctioned, *e. g.*, the use of large probes in the lachrymal duct, and of large instruments in certain other instances. The arm is inserted into the rectum, and the female urethra is dilated by the finger and the bladder explored. Nature's method of dilating the os was said to be by forcing a bag of water into it, and this process may be closely imitated by the use of the hand—introducing first a finger, then a second finger, and gradually the whole hand. There is hardly any cervix that cannot be dilated, with perhaps the aid of an assistant. This method was once practised quite extensively in Europe. Reference was also made to a series of cases published by Dr. A. D. Sinclair, of Boston, in the Boston *Medical and Surgical Journal*, in February, 1875.

The chief advantages of the method were claimed by Dr. Fuller to be as follows:

(1) The hand is always available.

(2) It is easily governed by the operator.

(3) The *finger* can always be introduced into the os when anything can be.

(4) The finger and hand and the operator are in sympathy, so to speak.

(5) All artificial aids require *manual* assistance.

(6) As the surgeon can often use his finger better than any instrument, so it is with the obstetrician.

The writer knew of twenty-one or twenty-two reported cases, of which sixteen made rapid and perfect recoveries.

The practice of manual dilatation requires the exercise of great patience, and no direct force is to be used. A constant and slightly forcible pressure is necessary,

gently introducing one finger after another. The skilful operator will be surprised to see how easily the object is accomplished.

These objections were mentioned and answered as follows: On account of danger of abrasion of the soft parts; but this is not necessary any more than from the passage of the fœtal head. Again, because it is difficult to accomplish; but this need not deter any practitioner of fair skill. Third, shock to the mother. This is no greater than when other methods are employed, and is perhaps less. Its effect on the child need not prevent its use, as the conduct of the case does not differ in the least, so far as the child is concerned, whatever the method of dilatation.

DR. W. G. STANLEY, of Slatersville, R. I., said he had employed this method in several cases of placenta prævia where there was excessive hæmorrhage early in the labor, necessitating prompt delivery, and that he had been surprised at the ease and quickness with which the os could be sufficiently dilated by means of the hand alone, to admit of version and delivery. No unfavorable results to mother or child had occurred in any of his cases.

DR. A. BALLOU related five cases of convulsions occurring between the fifth and sixth month of pregnancy. There were no signs of labor at the time, but the convulsions were undoubtedly of puerperal origin. His treatment was the same in each case, namely, venesection and an opiate in full dose. Membranes ruptured by the finger. When the effects of the opiate subsided labor came on, and a safe delivery was accomplished in less than twenty-four hours, followed by the recovery of the mother.

DR. GARVIN, of Lonsdale, cited the case of a primipara eight months advanced in pregnancy. There was an escape of liquor amnii, but no dilatation of the os, or pain. Convulsions began, and four occurred. The patient was seen by Dr. Garvin two hours later, who at once administered three-quarter grains of morph. sulph., hypodermically. Another convulsion occurred in an hour, when one-half grain more of morphia was given in the same way. Manual dilatation was performed, and delivery followed, after which there were three or four more convulsions, making nine in all. The woman recovered.

Dr. Garvin further said he thought it made great difference in the matter of forcible dilatation whether the subject was a primipara or a multipara, and that in first labors it was usually a mistake to interfere with the os uteri or the membranes.

DR. GEORGE CAPRON, of Providence, reported three cases of puerperal convulsions which had come under his observation.

CASE I.—Puerperal convulsions, and the patient an unfit subject for venesection. Morph. sulph., one-third grain, was given hypodermically. Relaxation of the os soon occurred, and delivery was accomplished. In the course of a few hours there were five more convulsions, and the same dose of morphia combined with atropia, one-twentieth grain, was given, also an enema of ol. terebinth, ℥i. The patient recovered, there being no recurrence of the convulsions.

CASE II.—Convulsions were occurring frequently, and labor was not far advanced. The pulse was not *full*, but was *hard*. The patient was at once bled to the amount of ℥xx. The child was soon born, and recovery followed.

CASE III.—The woman was known to have albuminuria. At 9 A.M. true labor began, with the os high up and inclined backwards. At 1 P.M. there had been little progress, and a full dose of pulv. Dover was given. At 4 P.M. there had been very little advancement, and there was still much rigidity of the soft parts. At 3 the next A.M., just as the forceps were about to be applied, a convulsion occurred. Venesection to the amount of f℥xxiv. was at once performed, the forceps applied, and delivery slowly and with great care accomplished, which was followed by a severe hæmorrhage. A little later a singular fit or seizure took place, the woman being rigid and unconscious, but not convulsed. She recovered.

Dr. Capron then proceeded to remark: (1) The favorable effect venesection has upon the labor itself, promoting rather than retarding it. (2) It is not claimed that venesection always stops puerperal convulsions, but its tendency is to ward off a condition of profound coma and other brain troubles. (3) It is best to use, in case of puerperal convulsions, small and repeated doses of morphia, rather than the large doses, one-half grain to one grain, that have been advocated. (4) Puerperal convulsions are due to uræmic poisoning. (5) It is true that morphia may arrest and control the convulsions themselves, but will it antagonize uræmia and cure the case? (6) It would be necessary to know that in the uræmic state there is great tolerance of morphia before using it in so heroic doses.

DR. CASWELL remarked that he had recently read of a number of cases occurring in Australia, where morphia had been successfully used in the large doses referred to for arresting puerperal convulsions.

Drs. Parsons, Caswell, and Fisher, having been appointed a committee to draw up a memorial

RESOLUTION ON THE DEATH OF DR. DAVID KING,

now reported as follows:

"*Whereas*, It has come to the knowledge of this Society that David King, M.D., long an eminent member of this Association, and an ex-President thereof, died at Newport, R. I., on March 7, 1882; therefore,

"*Resolved*, That in the decease of Dr. King the Rhode Island Medical Society has lost one of its most respected and honored associates, a physician of large culture and rare judgment, and a gentleman of the utmost urbanity and courtesy of manner.

"*Resolved*, That his connection with various literary, historical, and scientific organizations has reflected credit on the Society and the profession of medicine.

"*Resolved*, That the above resolutions be communicated to the family of the deceased, with the expression of our sympathy."

The Society then adjourned.

NEWS ITEMS.

UTICA.

(*By Telegraph from our Special Correspondent.*)

DR. JOHN P. GRAY'S CONDITION.—Dr. Gray is doing well. He sits up a portion of every day. The wound shows considerable union by first intention.

The Hon. W. H. Bright, of Utica, Dr. C. F. MacDonald, of the Insane Asylum for Criminals, at Auburn, and Dr. Flandrau, of Rome, N. Y., have been appointed a commission to examine into the assailant Remshaw's mental condition.

FOR several days after the shooting Dr. Gray's face was so badly swollen that it was thought best to wait for a few days before giving any further description. A late examination with measurements disclosed the following facts: The bullet (38 calibre) entered Dr. Gray's face just six-eighths of an inch below the outer angle of the left eye, passed five and three-eighths inches through the face, back of the nose and out through the right cheek, two and one-eighth inches below the outer angle of the right eye and one inch back of a vertical line drawn from that point, and from thence into the window-casing about five feet

from where the Doctor sat. The left side of his face was dotted with powder. Dr. Gray says that he has been in the habit of looking up when he heard any one approaching his door, and did so on this occasion. This movement of habit undoubtedly saved his left eye, if it did not actually prevent the bullet from crushing through his brain.

Almost immediately the left eye was closed by the effusion of blood into the lids, and the tissues surrounding, and within a short time the right eye was in a similar condition. The apertures in the cheeks, made by the bullet, were about the size of a silver three-cent piece.

The swelling in the face extended so that before Friday morning it was distorted beyond all recognition, and Dr. Gray was only able to see a trifle out of the right eye. The swelling extended to the neck by the infiltration of blood and serum. There has been no appreciable fever.

CINCINNATI.

(*From our Special Correspondent.*)

THE CINCINNATI ACADEMY OF MEDICINE will remove its quarters next week to the new building erected for, or altered to accommodate, the *Lancet* and *Clinic Press*. The old room on College Street will be vacated with reluctance, as it is ground sacred in the history of medicine in this city for nearly half a century. There is a general feeling that a hearty effort would secure money enough to erect a new building, to be the exclusive property of the Academy. The meetings are well attended, the discussions are animated and scientific, and are regularly reported and published by an efficient secretary.

MEDICAL COLLEGES.—There is a rumor abroad to the effect that one of the various regular colleges in this city (what a pity that they are so various) is about to effect an entire reorganization; features of which will be the restoration of several formerly discarded members of its faculty, and a reduction of fees to the lowest figures. The fees, and other matters of general interest, having been formally agreed upon by committees from the various colleges, and the cut-throat policy abandoned for many years, it is probable that any violation of the articles of agreement will be fought by the other schools. It is said that the other schools will not recognize the diplomas of cheap or second-class colleges.

THE ASSOCIATION OF MEDICAL COLLEGES will probably convene in Cincinnati in May, and it is to be hoped that it will be able to accomplish something in the way of advancing the cause of medical instruction. But since so many of the Eastern schools have withdrawn from the organization, chiefly on account of the compulsory third-term clause, it is probable that the abolition of this clause will be the principal object accomplished at this session.

BROOKLYN.

(*From our Special Correspondent.*)

SEA-SIDE HOME.—Effort is being made by the representatives of the medical societies of Brooklyn, and others, to secure upon Coney Island an eligible site for the Sea-Side Home for sick children, which has abundantly proved its usefulness during several summers, and has outgrown its quarters as of late provided.

THE LONG ISLAND CITY BOARD OF HEALTH has been established by the Common Council of that city.

CANADA.

(*From our Special Correspondent.*)

DOCTORS IN CANADIAN LEGISLATURES.—In contrast to England, where not a single constituency is represented by a member of the profession, Canada appears to have an unusual number of medical politicians. In the Dominion Parliament there are, in the Senate, 6; in the House of Commons, 16; of these, one, Dr. Blanchet, is Speaker of the House, and Sir Charles Tupper (M.D., Edin.) is Minister of Railways. In the Provincial Legislatures, Nova Scotia has 3; New Brunswick, 2; Manitoba, 2; Ontario, 10; and Quebec, 10. In the last-named province, the Lieutenant-Governor is Dr. Louis Robitaille, and the Minister of Agriculture, Dr. Ross.

OBITUARY.—Dr. Horatio Yates, of Kingston, Ontario, died on the 10th ult. He was for many years Professor of Medicine in the College of Physicians and Surgeons of that city, and the leading physician in the district.

VIENNA.

(*From our Special Correspondent.*)

GYNECOLOGICAL NOTES.—*Metro-Phlebitis.*—A case which has attracted, quite recently, much attention in gynecological circles in Vienna, may possess some value in American eyes.

A woman, thirty-one years old, presented herself at the Department of Diseases of Women, K. K., Allgemeines Krankenhaus, complaining of uterine hæmorrhages, recurring at irregular intervals, for one year; at no time very great in quantity. She was examined, and a small vascular tumor was found to occupy completely the os uteri. With this exception, the genital organs were normal. She was admitted into the hospital, and, a few days later, she complained of pain in the pelvic region. She went to bed, and symptoms, analogous to those of the puerperal process, immediately set in. On the eighth day after the examination she died. The *autopsy* revealed the uterine veins filled with pus and a very slight degree of pelvic peritonitis. When the uterus was examined, a small, pedunculated, vascular, fibroid tumor, not larger than a raisin, was found to spring from the lateral wall, inner surface of the uterus, and extend through the cervix to the os uteri. The peduncle was twisted, and the fibroid tumor was congested and slightly gangrenous. It was supposed that in the examination, though very carefully conducted, the peduncle had been twisted, the nutrition of the tumor arrested, and a sufficient cause for gangrene and the resulting metro-phlebitis given.

Vesico-Vaginal Fistula.—In vesico-vaginal fistula, BILLROTH places his patient on her back, with the legs supported by assistants, as in lithotomy. To bring the parts in position, he employs Simon's speculum and spatula, and a number of retractors, held by assistants. The edges of the fistula are pared with right- and left-handed knives; the edges of the wound are united by silk sutures; the wound is thoroughly douched with a three per cent. solution of carbolic acid; and the vagina well plugged with iodoform gauze. The patient is catheterized, at regular intervals, for three days. The operation is very rapidly performed, and is usually attended with perfect success.

THE CHAIR OF PATHOLOGY, UNIVERSITY OF VIENNA.—Hans Kundrat, Professor of Pathology in Gratz, has been elected, within the last few days, to the chair of pathology, K. K., University of Vienna, made vacant, nine months since, by the death of Prof. Heschl. It will be remembered that this chair was first raised into prominence by the great labors of Rokitansky. Since Heschl's death, Prof. Chiari has lectured upon pathology. That the chair, formerly occupied by so great a master as Rokitansky, should be awarded to a man known to the world by no important original researches, and possessed of no special talent as teacher or lecturer, causes a great amount of secret discontent in

Viennese medical circles. It is rare, however, that such discontent finds audible expression, as the University of Vienna is truly a "Royal and Imperial" institution (Königliche und Kaiserliche). It appears that Prof. Kundrat's father is a valet to the emperor, and that, through his influence, Arnold, of Heidelberg, the choice of the Faculty of Medicine, was rejected.

Obstetrical Notes.—*Labor Complicated by an Enlarged Fœtal Liver.*—An unusual complication in labor occurred to-day in the lying-in ward of Prof. Josef Spaeth, K. K., Allgemeines Krankenhaus. The patient was thirty-five years old, a multipara, with no history of previous labor complications. The last pregnancy presented no features worthy of special notice. Yesterday she fell in labor at full term; the bag of waters ruptured early. The diagnosis of head presentation, second position, was easily made, and the heart of the fœtus was heard to beat regularly. Twenty-four hours later, after a tedious first-stage, the head was born, but the trunk did not follow. After waiting some minutes, the midwife called the second resident accoucheur, Dr. E. Ehrendorfer, for assistance. Vaginal examination revealed the mouth of the uterus tightly encircling the thorax of the fœtus, while the uterus was tetanically contracted. After ineffectual attempts at extraction of the fœtus, the woman was chloroformed, when the spasmodic contraction at once ceased, and the fœtus was drawn out of the cavity of the uterus dead. The abdomen of the child was enormously distended by a slightly elastic tumor, occupying the position of the liver. This tumor offered far more resistance to the maternal passages than the head. Upon opening the abdomen the liver was found to be immensely enlarged, occupying the greater portion of the abdominal cavity, and infiltrated with syphilitic gummata. The placenta, which came away naturally, presented to the naked eye no abnormal appearances.

Prophylaxis of Ophthalmia Neonatorum.—Credé has recently added to his 200 cases of observation of newly-born infants, 400 more. In 300 of these infants, at the same time with the first bath, both eyes of each child were carefully cleansed with a soft rag, and one drop of a two per cent. solution of nitrate of silver was let fall into each eye by means of a glass pipette. Although most of these children were born under most unfavorable conditions, in no case thus treated did ophthalmia neonatorum occur. Credé is very enthusiastic over this method of prevention of disease, and warmly recommends it as by far the most efficient means.

Ergot of Secale Cornutum.—The favorite oxytocic in Vienna is the ergot of secale cornutum. For administration by the mouth, an infusion is employed. For hypodermic medication a dialysed ergotin, prepared by a Parisian apothecary, E. Bombelou, is used. It is claimed that this preparation causes much less local irritation than the ergotin of Wiggins or Boujeau, and that it is much more rapidly absorbed, more efficient in its action.

Resignation of Prof. Gross.—On the 27th ult., Prof. Samuel D. Gross tendered to the Trustees of the Jefferson Medical College his resignation of the professorship of surgery which he has held in that institution for twenty-six years.

Dr. Gross is seventy-seven years of age, and, although still in the enjoyment of vigorous health, recognizes the wisdom of lightening his labors with advancing years. Dr. Gross's world-wide reputation as a surgeon, and popularity as a lecturer, have justly attracted large numbers of students to the Jefferson School, and his resignation is a serious loss to the Faculty and to medical education in Philadelphia.

The Public Health.—The following statistical data for the *week ending March 18*, were received too late for our last issue. During this week there were 22 deaths from *small-pox* in Chicago; 3 in Hudson Co., N. J.; 7 in Richmond, Va.; and 11 new cases in the District of Columbia; 8 in Richmond, and 2 in Detroit. *Cerebro-spinal meningitis* caused 2 deaths each in Chicago, Hudson Co., N. J., Detroit, and Buffalo; and 1 death each in San Francisco, Omaha, and Salt Lake City. The deaths from *croup* were 12 in Chicago, and 2 in Detroit. There were 9 deaths from *diphtheria* in Chicago, against 11 and 14 reported the two preceding weeks; 7 in Detroit; 4 in Hudson Co., N. J.; 4 in San Francisco; 3 each in the District of Columbia and Buffalo, and 1 in Salt Lake City, the first reported for several weeks. The deaths from *typhoid fever* were 5 in Chicago; 3 in Hudson Co., N. J.; 2 in Buffalo, and 1 each in the District of Columbia, Richmond, Nashville, San Francisco, and Salt Lake City. From *scarlet fever*, 3 deaths in Chicago; 7 in Hudson Co., N. J.; 3 in Buffalo; 2 each in Detroit and San Francisco, and 1 each in the District of Columbia and Nashville. From *measles*, 8 deaths in Chicago; 3 in Detroit; 1 in Buffalo, and 7 in San Francisco. From *whooping-cough*, 2 deaths each in San Francisco and Nashville, and 1 death each in Chicago and the District of Columbia. The last paragraph in the first column of page 337 refers to the mortality in the city of San Francisco.

The following is a brief statement of the principal features in the mortality returns for the *week ending March 25* in a number of prominent places:

Small-pox.—In Cincinnati, where this disease has been very prevalent, the returns for the week show a very marked falling off in the number of deaths as compared with several preceding weeks. In other places there is no special change in the mortality reports to be noted. There were 14 deaths in New York City; 11 in Philadelphia; 8 in Pittsburg, with 36 new cases; 22 in Cincinnati; 28 in Chicago; 2 in St. Louis; 1 in Dayton, O.; and 2 in Memphis. 13 new cases were reported during the week in Dayton, O.; 12 in St. Louis; and 2 in Milwaukee. The epidemic in South Bethlehem, Pa., appears to be rapidly abating. But few new cases have been reported during the week, though a number of deaths have occurred from among persons whose cases were included in the number reported the previous week. There have been 49 deaths up to and including the 28th of March.

Cerebro-spinal Meningitis.—But few deaths were caused by this disease during the week. New York City reports 5 deaths; Pittsburg and Chicago, each 3; Philadelphia and Cincinnati, each 2; and Memphis, 1 death from this cause. Elsewhere the disease does not appear in the mortuary returns.

Croup.—Ten out of eighteen places report deaths from croup as follows: New York City, 26; Philadelphia, 10; Chicago, 9; New Haven, 2; and Louisville, Milwaukee, Indianapolis, Pittsburg, Providence, and Nashville, each 1.

Diphtheria.—A further decrease in the number of deaths from diphtheria is noticed in Boston and New York City, and a slight increase in the number in Philadelphia. The returns, so far as received, are as follows: New York City, 33; Philadelphia, 10; Boston, 6; New Haven, 3; Chicago, 11; Pittsburg, Cincinnati, and Indianapolis, each 2; and Milwaukee, Louisville, St. Louis, Shreveport, and Dayton, O., each 1. There were 29 new cases reported in Boston during the week.

Scarlet Fever.—The deaths in New York City from scarlet fever were 82, while in the two preceding weeks the numbers were respectively 79 and 81. It is interesting to note the almost exact uniformity in these returns for several weeks in a population of over 1,000,000 of inhabitants. The disease also remains about sta-

tionary in Boston and Philadelphia. In the former city there were 2 deaths and 11 new cases; in the latter there were 7 deaths. In St. Louis there were 7 deaths.

Typhoid and Typhus Fevers.—It is noticeable that only 3 deaths occurred from typhoid fever in New York City, the smallest number reported for many weeks. In Philadelphia there were 13 deaths, an increase of 2 over the previous week; in Chicago, 8; in Indianapolis, 5; in Pittsburg, 4; in Boston and Cincinnati, each 2; and in Charleston, Milwaukee, and Louisville, each 1. Nine new cases were reported in Boston. The only city in which typhus fever appears to be present is New York, where there were 6 deaths during the week, an increase of 5 over the number reported the week previous.

Measles and *whooping-cough* do not appear to be very prevalent in any place except New York City. From measles there were 24 deaths in New York City; 9 in Chicago; 2 in Philadelphia; 3 in Pittsburg; and 1 in New Haven. Whooping-cough caused 14 deaths in New York City; 2 each in Chicago, Portland, and Providence; and 1 each in Philadelphia, Boston, Nashville, Dayton, O., and Milwaukee.

Consumption and Pneumonia.—By far the most prominent causes of death at this season of the year, with few exceptions, are consumption and pneumonia. The loss of life by these diseases is enormous. From consumption there were no less than 97 deaths in New York City; 53 in Philadelphia; 35 in Boston; 22 in Chicago; 12 in St. Louis; 9 in Pittsburg; 8 each in New Haven and Providence; 14 in Cincinnati; 11 in Louisville; 5 in Nashville; 4 in Dayton, O.; 2 each in Wilmington, Del., Indianapolis, Milwaukee, and Memphis; and 1 in Augusta. From pneumonia there were 101 deaths in New York City; 40 in Philadelphia; 32 in Chicago; 10 in St. Louis; 17 in Boston; 8 in Pittsburg; 6 in Cincinnati; 4 each in Providence and Louisville; 3 each in New Haven and Milwaukee; 2 each in Augusta and Indianapolis; and 1 each in Portland, Wilmington, Del., and Memphis.

Jacksonville, Fla., with a population of 8000, reports 5 deaths for the week from all causes, 4 of them occurring among non-residents.

HEALTH IN MICHIGAN.—The State Board of Health Bulletin for the week ending March 18, 1882, indicates that neuralgia, intermittent fever, and erysipelas have increased, and that pneumonia, tonsillitis, rheumatism, and bronchitis have decreased considerably in area of prevalence.

Small-pox was reported at 4 places, as follows: At Spalding, Menominee Co., and among the Indians near Spalding, March 15; at Detroit, March 18; at Grand Rapids (1 new case from Chicago), March 21, 1882.

STATE MEDICAL SOCIETY MEETINGS.—The Tennessee State Medical Society meets on April 4; the Kentucky State Medical Society at Louisville on April 5; and the Mississippi State Medical Association at Oxford on the same day.

MAINE MEDICAL SCHOOL.—Dr. S. H. Weeks has been appointed to the Chair of Surgery in the Maine Medical School; Dr. Henry F. Gerrish, Lecturer on Anatomy, and Dr. Chas. O. Hunt, Lecturer on Materia Medica and Therapeutics.

MEDICAL COLLEGE COMMENCEMENTS.—The Medical College of Indiana held its Commencement on March 1, and conferred the degree of M.D. on 61 candidates.

The Central College of Physicians and Surgeons of Indianapolis held its Third Annual Commencement on the 28th of February. There were 8 graduates, 2 of whom were women.

The Commencement of the Memphis Hospital Medical College was held March 1, 36 degrees were granted.

The Medical Department of the University of Kansas held its first Annual Commencement on March 2, 10 degrees were conferred.

The Commencement of the Northwestern Medical College, St. Joseph, Mo., was held February 20, 7 degrees of M.D. were granted.

The Third Annual Commencement of the Southern Medical College of Atlanta, Ga., was held March 1, 47 degrees were granted.

MEDICAL LITERARY ASSOCIATION.—A number of physicians of this city have permanently organized the D. Hayes Agnew Medical Literary Association by electing as officers for the current year: President, Dr. F. O. Nagle; Vice-President, Dr. G. P. Oliver; Secretary, Treasurer, and Librarian, Dr. G. Maxwell Christine. Among the objects of the association are the circulation of medical books, pamphlets, essays, and journals, and at the monthly meetings of the body discussion of subjects relative to the profession. The meetings are held on the evening of the first Tuesday in each month.

THE GROSS MEDICAL AND SURGICAL SOCIETY, named in honor of the distinguished Philadelphia surgeon, has recently been formed in Louisville, Ky., his old home.

L'UNION MÉDICALE.—Prof. Gustave Richelot has been appointed to the post of Chief Editor of "*L'Union Médicale*," in the place of Dr. Amédie Latour, who, after conducting the journal with vigor and ability during the thirty-five years of its existence, is compelled to retire on account of failing health.

THE RADICAL CURE OF CANCER.—Dr. J. Collins Warren who, in October last, was delegated to receive competing essays on the subject of the radical cure of malignant disease, announces that three essays were presented, but after due consideration of their merits it was decided that no essay was worthy of a prize. The same subject, namely, "The Probability of the Discovery of a Cure of Malignant Disease, and the Line of Study or Experimentation likely to bring such a Cure to light," is proposed for essays to be presented in competition not later than the first day of December, eighteen hundred and eighty-three (1883), to Dr. Warren who, with such assistance as he may select, will be the judge of their merits.

For the best essay on the above subject a prize of one thousand dollars will be given, the right being reserved to withhold the prize in case no essay of sufficient merit be presented. The essays must be legibly written in English, and neatly bound. Each one must bear a motto, and be accompanied by a sealed envelope bearing the same motto, and enclosing the name and address of the writer. They will all remain in the possession of the donor of the prize for convenience of reference, and the privilege is claimed to publish the successful one, with the name of the writer. No writer, however, surrenders the privilege of retaining a copy of his essay, and publishing it. The decision concerning the merits of the essays will be made chiefly from a practical standpoint, it being the object of the donor of the prize to obtain suggestions by which a search for a cure for cancer may be instituted.

PERMANENT BATHS.—The *Tägliche Rundschau*, of Berlin, reports that a patient under the care of Prof. Langenbeck, of Berlin, underwent an operation last year, since which time he has passed twenty-four weeks lying in water, and has recently been discharged quite restored to health. It is remarked that the practical utility of permanent baths is rapidly gaining more gen-

eral recognition. In cases of severe burns, where the warmth of a bed is hurtful to patients, this system is said to be particularly applicable. Of course permanent baths cost a good deal, as an accurate regulation of temperature is needful if a patient remains in one for a length of time. The cost of gas for a bath is estimated at 150 marks (£7 10s.) per month.—*Lancet*, Feb. 25, 1882.

An Artificial Substitute for Quinia. — The progress of synthetic chemistry is said to have at last provided an effective substitute for quinia. This substance, chinoline, is, indeed, a derivative of the cinchono, and some other alkaloids, from which it was obtained by distillation, as long ago as 1842, by Gerhardt, who termed it, from its oily aspect, "quinolein." Soon afterwards Hofmann showed that it was identical with an organic base which Runge, in 1839, obtained from coal-tar, and which he had termed "leukoline." The remarkable fact that from coal-tar could be obtained the same base which was yielded by quinia has remained for forty years unnoticed, in spite of its suggestiveness. Lately chinoline has been found to possess considerable therapeutic value, and to be producible by a much simpler synthetic process. Skraup has ascertained that it may readily be produced by heating aniline or nitrobenzol with glycerine, and this process is now employed for its commercial preparation. According to Donath, Salkowski, and Loewy, chinoline is an efficient substitute for quinia in malarial fever, dose for dose, and sometimes it is even more certain in its action. Unfortunately, it causes considerable gastric irritation in some cases. It is an exceedingly powerful antiseptic agent, superior even to salicylic and carbolic acids, and seems likely to play an important part in the antiseptic surgery of the future. Most of its salts are deliquescent, but the tartrate is crystalline and stable; its cost is one-fifth that of quinia.

In a note published in the *Pharmaceutical Journal*, Mr. Charles Ekyn throws doubt, however, on the identity of most commercial preparations of chinoline, obtained from coal-tar, with the old leucoline produced by the distillation of cinchonine, etc. A specimen obtained from Germany as pure chinoline was found on analysis to consist for the most part of a mixture of aniline and nitrobenzol. Another specimen contained traces of these substances, and although it had the characteristic odor of chinoline and gave the proper reaction with potassium bichromate (a crystalline yellow precipitate), it did not form blue cyanine when treated with amyl iodide, although this reaction is readily obtained with pure chinoline (from cinchonine.) It is probable that the German so-called chinoline is a mixture of homologous bodies, and a thorough investigation into its properties seems desirable. It has been given abroad in large doses as a substitute for quinia, and it is needless to say that the presence of a considerable quantity of nitrobenzol would give rise to unpleasant effects.—*Lancet*, Feb. 25, 1882.

Red Sweat.—It has long been suspected that the red as well as the blue color occasionally observed in perspiration is due to the presence of bacteria. In a woman whose sweat, especially in the axillæ, had a red tinge, Hofmann, in 1873, found that uniform red masses adhered to the hairs, but he did not ascertain their nature. Pick observed in a peculiar case of skin disease reddish masses of bacteria on the hairs. Eberth noticed bacteria in yellow sweat. Additional observations of the same kind have been reported by Babesiu, of Pesth. A woman twenty-six years of age presented pale-red sweat in the right axilla, where the skin and hair were also slightly reddened. From time to time the perspiration became blood-red in color, associated with hysterical and nervous disturbances. A sister who slept with her also became affected in a similar manner, the perspiration in the right axilla becoming red. A third case presented itself in a young healthy man, who complained of occasional blood-red sweat; and a fourth in a young woman. In all the symptom was associated with troublesome itching. Microscopical investigation yielded in all the cases a similar result. The hairs of the axilla were thin, pale-red, brittle, and surrounded with a colloid-looking, rusty or bright-red sheath, in places of considerable thickness, and having a rough surface. It consisted of red masses presenting a radiating striation, more or less confluent, apparently proceeding from fibres of the cortex of the hair or from some broken part of its surface. The radiating striation was found to be due to the aggregation of round or ovoid bacteria, scarcely a micro-millimetre in diameter, which were united in zooglœa masses by a reddish intermediate substance. Nodular swellings on the hair were produced by an infiltration of the organism between the separated fibrils. The roots of the hair were free from bacteria. The red tint of the sweat was found to depend upon numerous roundish masses of zooglœa, resembling those of Bacterium prodigiosum. The bacteria were deeply colored by anilin and hæmatoxylin, and were rendered more distinct on the addition of acetic acid or liquor potassæ, while the zooglœa shrank under the influence of alcohol, ether, and turpentine. Sulphuric acid changed the red color to violet, and then to violet-blue. In sterilized culture solutions the bacteria multiplied slowly. The conclusions drawn from these observations are that the red sweat often found in the axilla is colored by a sphero-bacterium, the development of which gives rise to an excessive perspiration, and sometimes to brittleness of the hair, itching, and slight tinting of the skin. The red sweat appears to be contagious. The bacteria resemble, on the one hand, the colorless zooglœa found in hair, and, on the other, certain chromogenous bacteria, especially B. prodigiosum, from which it is distinguished by the brick-red color of the intermediate substance. It is more difficult to cultivate than B. prodigiosum, but gives essentially the same chemical reactions. — *Lancet*, March 11, 1882.

Congratulatory Address to the Queen.—At a meeting of the Royal College of Physicians, London, on Tuesday the 7th inst., the President alluded to the recent attempt to assassinate the Queen, and it was unanimously agreed that an address should be drawn up and presented to Her Majesty, and a Committee of Fellows was appointed for that purpose.—*Lancet*, March 11, 1882.

Harvey's Tomb.—At an extraordinary meeting of the College of Physicians of London, held February 23, Dr. B. W. Richardson informed the President and Fellows that he had recently visited the church at Hempstead, and had inspected the vault which contains the remains of Dr. William Harvey. The tower of the church had very lately suddenly fallen, but Harvey's coffin had fortunately not been injured. It was, however, so decayed and so exposed that the rain found ready access to the interior, and he felt sure that the College would desire that something should be done to insure the preservation of the remains of their illustrious Fellow and benefactor. It was resolved that a committee of five should be appointed, with the President and the Senior Censor, to consider what steps should be taken to insure the preservation of Harvey's remains, endangered by the falling of Hempstead Church, and to report to the College. The committee appointed were: Sir Risdon Bennett, Dr. Acland, Dr. Quain, Dr. Richardson, and Dr. Stewart.—*Med. Times and Gaz.*, March 11, 1882.

PLURAL BIRTHS.—In his last annual report on Bethnal Green, Dr. Bald mentions the occurrence of four births at one time—two boys and two girls. The girls were still-born; the boys lived forty-six and sixty-nine hours respectively.

JUMBO.—It seems that the sale of Jumbo, the pet elephant of the London Zoological Garden, was not due to signs of approaching insanity, but because of his having reached the period of life when he is capable of reproducing his species, and it is the fear of violence resulting from his forced continence which influenced the Council to part with him. Mr. Barnum has a family of elephants, and Jumbo will require soothing female influences for the next year or two.

WHAT IS SAID ABOUT THE NEW YORK CODE OF ETHICS.

So decided a step in advance, that we forbear to comment upon the trivialities and commonplaces that make up the bulk of the document.—*New York Medical Journal.*

Its adoption cannot be regarded as a retrograde step.—*Chicago Medical Review.*

The effect of a practice or ethical custom firmly established in such a centre as New York upon the general profession of the country must, in the course of years, be very marked.—*Philadelphia Medical Times.*

Will commend itself to many as the preferable guide to one physician's conduct towards another and to the public.—*Michigan Medical News.*

A step in the right direction, and is in so far a great improvement over the American Code. . . . It is impossible to resist the conviction that it is one of wise liberality.—*Medical Record.*

They have stood in the way of progress in therapeutics just as long as they dared, and have cracked the whip of medical exclusiveness and sectarian bigotry, until at last it has dawned upon their minds that they have frightened no one, but have aroused a feeling of contempt for their course among all frank, honest-thinking men, and what is more to the purpose in bringing them to their senses, are interfering with their own bread-winning. Is it any wonder that the old school, with a shrewd eye to the dollars and cents, are beginning to appreciate the fact that in the future sectarian utterances and exclusiveness in medicine will not pay?—*New York Medical Times* (Homœopathic).

The revision is of such a character that it bids fair to be the entering wedge to a general breaking up of old things and a liberation of the fossils of regularism.—*The Physio-Medical Journal.*

With all this millennium of homœopathy absorbing the old school, and both calling each other "regular," there is a dark cloud still hanging over their mutual admiration.—*Medical Tribune.* (?)

What does all this mean? It simply means that the code of ethics heretofore prohibiting members of the so-called regular profession from meeting eclectics and homœopaths in consultation is no more; that the effort to ostracize a large class of intelligent, well-educated, and enterprising physicians, by refusing to meet them in counsel, is no longer regarded as being expedient or humane in character. This is an important step in the right direction. . . . . We hope other societies will imitate the example of the New York State.—*The American Medical Journal* (Eclectic).

This action on the part of an influential society has opened the ethical door, through which many easy-going consciences can pass; but let us hope that the better portion of the profession will, as they always hitherto have, regard it honestly impossible to professionally meet those whose methods of curing disease they consider fallacious and invaluable.—*The Medical and Surgical Reporter.*

We must believe that a great mistake has been made by the Committee in revising the Code and by the Society in accepting it, and we trust that some effort will be made as early as possible to undo the wrong which has been done, we will say unconsciously, but it seems to us stupidly. We would not, of course, say intentionally.—*The Medical Gazette.*

The proposition of the Society of the State of New York to hold consultations with all legally-qualified practitioners of medicine, does not exclude the licensed cancer quack, the midwife, and the chiropodist. It embraces all the pathies. Now, this is called ethics, and we are plainly informed by the *Record* that this is reform. Fortunately, the provisions for enforcing this code of defiance to all ethics and common decency are limited to the prostitutes of professional morals, and the country may yet be saved.—*The Medical Herald.*

Cannot help regarding the movement as being very dangerous and unwise, and as being an important step in the direction of professional disintegration and decay. —E. R. Squibb, M.D., in *Ephemeris of Materia Medica.*

The door might thereby be thrown wide open for the entrance of numberless abuses, and the result be a perceptible lowering of the whole standard of medical ethics, already none too high.—*Buffalo Medical Journal.*

It is our belief, that however the commercial spirit may dominate the profession of the State of New York, it will not dominate every other State.—*The Detroit Lancet.*

The sole object in view in the adoption of this Code seems to have been to open the doors for consultation with irregulars.—*The Physician and Surgeon.*

But, surely, "the times are out of joint" most strangely when a medical society representing the professional dignity and intelligence embodied in that of the State of New York can by a two-thirds majority adopt a Code of Ethics expressly abandoning the clauses which forbid participation in the farce of consultation with the dogmatists of any exclusive therapeutic sect or school; and when a medical journal of the standing and previous respectability of the *New York Medical Record* can be found not only to connive at, but to defend the action.—*The Canadian Journal of Medical Science.*

How a code with such a clause could be adopted by a society in good standing, is absolutely incomprehensible.—*Gaillard's Medical Journal.*

OFFICIAL LIST OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT, U. S. ARMY, FROM MARCH 20, TO MARCH 27, 1882.

ALEXANDER, R. H., *Major and Surgeon.*—Having reported at these Headquarters, will report to the Commanding Officer, District of New Mexico, Santa Fé, for duty as Attending Surgeon at District Headquarters, and Post Surgeon, Fort Marcy, New Mexico. —*S. O. 59, Department of the Missouri, March 20, 1882.*

TREMAINE, W. S., *Captain and Assistant Surgeon.*—Assigned to duty at Fort Porter, New York.—*S. O. 51, Department of the East, March 24, 1882.*

DICKSON, J. M., *Captain and Assistant Surgeon.*—Assigned to duty at Fort Adams, Rhode Island.—*S. O. 51, Department of the East, C. S.*

DICKSON, J. M., *Captain and Assistant Surgeon.*—So much of Paragraph 2, S. O. 51, C. S., as relates to him is revoked, and he will proceed to Fort McHenry, Maryland, and report to the Commanding Officer for duty at that Post.—*S. O. 52, Headquarters Department of the East, March 25, 1882.*

THE MEDICAL NEWS *will be pleased to receive early intelligence of local events of general medical interest, or which it is desirable to bring to the notice of the profession.*

Local papers containing reports or news items should be marked.

Letters, whether written for publication or private information, must be authenticated by the names and addresses of their writers—of course not necessarily for publication.

All communications relating to the editorial department of the NEWS *should be addressed to No. 1004 Walnut Street, Philadelphia.*